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Methadone in Irish General Practice: Voices of Service Users

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<p>METHADONE IN IRISH GENERAL PRACTICE: VOICES OF SERVICE USERS</p>
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VOLUME 1 OF 3

**A THESIS SUBMITTED FOR THE DEGREE OF DOCTOR OF
HEALTH**

BY LINDA LATHAM

**SCHOOL FOR HEALTH UNIVERSITY OF BATH
SEPTEMBER 2010**

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Linda Latham

DECLARATION

I Linda Latham confirm that this dissertation and the work presented in it is my own achievement. I have made clear that my research follows on from my previous work: *An explorative study of the perceptions and experiences of Practice Nurses in relation to patients on a Methadone Treatment Protocol* (Latham 2003).

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ABBREVIATIONS

CDTL	Central Drug Treatment List
DOH	Department of Health
DOH	Department of Health
DOHC	Department of Health and Children
DTC	Drug Treatment Center
ERHA	Eastern Regional Health Authority
GP	General Practitioner
HSE	Health Services Executive
ICGP	Irish College of General Practitioners
MMT	Methadone Maintenance Treatment
Phy	Physeptone

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THE GREEN LEASHE

THERE'S THIS GREEN MEDICINE THAT I TAKE
IT TAKES OVER MY BODY AND MAKES ME FAKE
IT RUNS THROUGH MY BODY AND THROUGH MY VEINS
UNTIL IT RUNS THROUGH MY BODY AND HITS MY BRAIN

YOU ARE TREATED LIKE A SECOND CLASS CITIZEN FROM DAY ONE
EVEN THOUGH YOU HAVE DONE NOTHING WRONG
YOU ARE TRYING TO GET BACK TO NORMALITY
BUT THEY THINK YOU NEED SYMPATHY
WHEN ALL YOU WANT IS TO BE FREE

THE AUTHORITES TREAT YOU WITH DESPISE
EVEN THOUGH YOU'VE DA BEST LIES
THEY ALL SAY THEY ARE THERE FOR YOU
WHAT ABOUT ALL THE REST OF THE PEOPLE THERE FOR YOU TOO?
IT STARTS TO COME TO PEOPLE YOU TRUST
AND THEN ONCE YOU GET OFF A CLINIC TO DA CHEMIST -EVERY THING
CHANGES.

YOU COULD BE THERE FIRST AND THEY TALK AND HAVE A LAUGH
BUT WHEN A PAYING OR NON PHY PATIENT COMES, YOU'RE LEFT LIKE
RUBBISH PUT IN A BIN

THEY WAIT TILL THEY ARE GONE AND THEY SAY, RIGHT! COME ON
I'VE BEEN THERE 20-25 MINUTES, IF I WAS COLOURED OF ETHNIC RACE, IT
WOULD BE CALLED RACISM, BUT THEY SAY 'SELF- INFLICTED'
YET THEY MAKE MONEY OFF OUR BACKS, I WISH THEY WERE ON THE OTHER
SIDE OF THE TRACKS

I CAN'T GO ON A HOLIDAY ON A WHIM, DA GREEN LEASHE SHE REELS ME IN
THAT'S WHAT I HAVE TO SAY AND BELIEVE
I'M IRISH BORN AND BRED YET I AM A THIRD CLASS CITIZEN
IT'S BLIND RACISM, YET I CAN'T SPEAK OUT, IT'S LIKE THEY OWN YOU
(SIC -A PARTICIPANT)

SUMMARY

This study sets out to make a meaningful and useful contribution to the discussion surrounding the treatment of heroin addiction in the Republic of Ireland. The exploration describes the experiences of service users who are receiving methadone treatment in general practice in Dublin and provides recommendations for practice.

A Husserlian phenomenological approach drawing on the psychological research methods of Colazzi informed this study. This qualitative descriptive genre was coupled with the genre of reflexive methodology and utilised the techniques of bracketing interviews and polyvocality. The study took place in nine urban general practices in Dublin city. Twenty five service users were interviewed in-depth. The data were analyzed using the methodology espoused by Collazzi (1978).

Four themes emerged from the data: *Service users' experience of attending general practice for methadone maintenance; The significance of methadone for the service user; Service users' understanding of the Methadone Treatment Protocol and The experience of addiction and it's effect on families.*

Service users' accounts traced the historical steps that influenced the introduction of the MTP. Their depictions of their experience of treatment shed light on the process of care in general practice and how clinical guidelines have been interpreted and developed locally. The study identified what it is that affects the delivery of methadone treatment from the users' perspective. It provides insight into the harm reduction policy of methadone maintenance and highlights how, from the service users' own experience, the implementation is falling short.

The data identify that the delivery of methadone treatment requires a sustained policy review, informed by a clinical perspective on all issues related to regulations, practice guidelines, and treatment resourcing.

The recommendations suggest that to be truly effective, strategies which recognize the importance of user involvement need to be addressed.

CHAPTER 1: LITERATURE REVIEW

1. HISTORY OF METHADONE TREATMENT

The history of methadone maintenance treatment (MMT) internationally dates from the early 1960s. Nyswander and Dole pioneered the prescribing of oral methadone, basing their approach on the theory that once addicted, opiate addicts suffer from a metabolic disorder, similar in principle to disorders such as diabetes. Just as insulin normalizes the “dysfunction” in diabetes, so methadone was proposed to normalize the “dysfunction” of opiate addiction. Methadone is a synthetic opioid and high doses from 80mg to 150mg were advocated to establish a pharmacological blockade against the effects of heroin that would prevent addicts from experiencing euphoria (Dole & Nyswander 1967). The key features were long term treatment, high doses of methadone and a comprehensive set of psychological and social services to assist the person to reintegrate into mainstream society.

From this initial approach to treatment, there has followed a plethora of literature in relation to the function of methadone, its use as a substitute treatment for opiate addiction and the definition of treatment goals. These have ranged between long term maintenance, to low threshold programmes and detoxification, to achieving abstinence within a period of a few years (Dole & Nyswander 1967, Ward *et al* 1998, Farrell *et al* 2000, Ward 2002, Fraser & Valentine 2008).

The implementation of methadone maintenance as a harm reduction initiative has been greeted internationally as a successful policy in many respects. In public health, harm reduction describes a concept which aims to prevent or reduce negative health consequences associated with drug misuse. Harm reduction for drug misusers aims to help them avoid the negative health consequences of drug misuse and improve their health and social status (WHO 2003). The United States National

Association for Public Health Policy, the Canadian Centre on Substance Misuse and the World Health Organization have all endorsed the principles of harm reduction in key documents (CCSA 1998, NAPHP 1999, WHO 1999). MMT has been shown to benefit drug misusers as well as providing public health and social benefits and the justification for its use is based on the principle that 'the benefits far outweigh the risks associated with it' (Bell & Zador 2000, Negrete 2001, Ward 2002:6). This theory and experience has been influential in establishing harm reduction policies around the globe but not without the counter-arguments, which are skeptical about the "evidence base". The evidence supports the benefits of MMT as reductions in crime, drug related mortality and HIV infection (Harwood *et al* 1988, Ward *et al* 1998, Bell & Zador 2000, Sorenson & Copeland 2000, WHO & UNODC 2004, Humeniuk & Ali 2005, Irawati *et al* 2006) and also demonstrates that MMT can keep people who are dependant on heroin in treatment programmes and reduce their use of heroin (Mattick *et al* 2006, 2008, 2009).

Despite having been implemented and evaluated for in excess of forty years, methadone maintenance has remained a divisive treatment (Ward 2002, Dyer 2002, Lally 2003, Grehan 2007). This is in spite of the lack of evidence to prove the effectiveness of psychosocial interventions alone for the treatment of opiate dependence or the superiority of any other type of treatment (Mayet *et al* 2004).

Methadone is one of several medications used in the treatment of opioid dependence and the majority of methadone programmes have deviated from the original model proposed by Dole and Nyswander (Lawless & Cox 2003). Internationally, MMT is a highly regulated regime that is subject to complex governance structures. Regulations and operational cultures vary between countries such as Australia and the United Kingdom (UK) and the United States (US). Treatment generally combines general practitioner (GP) and specialist services;

however in the US almost all clients receive their methadone in specialist clinics (Fraser & Valentine 2008). The phenomenon of MMT as a heavily regulated treatment for heroin dependence has had little attention from the perspective of social and cultural theorists and debates about the validity of treating addiction as analogous to a chronic disease such as diabetes continue to influence both the organization of drug treatment and the social recognition of illicit drug misuse (Fraser & Valentine 2008:5).

The introduction of the harm reduction strategy of MMT has been controversial in the Republic Of Ireland (RoI) (O'Brien & Dillon 2000). This strategy presented a significant shift from a historical model of abstinence as the policy issues were highly sensitive to a new treatment initiative (Butler 2002, Butler & Mayock 2005). Butler (1991) identified that although the establishment of services which were aimed at harm reduction rather than total abstinence corresponded to similar developments in other countries, the important difference was that most other countries had some previous history of harm reduction and so did not experience such a major ideological shift. A brief overview of the historical background is important in order to understand how the structure of MMT developed in the RoI.

1.1. IRISH HISTORICAL BACKGROUND AND THE STRUCTURE OF THE METHADONE TREATMENT PROTOCOL

Opiate misuse in Ireland intensified in the 1980s. Central service treatment facilities for drug addiction in Dublin, which had been provided since 1969 were becoming overwhelmed by the growing number of "out-of-control" drug misusers (Butler 1991, Latham 1998, Cullen 2000). Internationally the problem of drug misuse was also escalating and public health issues associated with HIV infection

prompted the first serious efforts to respond to the problem (Morgan 2001). A governmental task force was established to examine the question of drug misuse with particular reference to inner city areas. The *Government Strategy to Prevent Drug Misuse* (DOH 1991) was based on the recommendations of that committee. The training of GPs in managing heroin addicted clients was recommended and the committee stated that they also 'saw the merit' of exposing other health professionals, such as nurses, to the problems associated with drug misuse in the community (DOH 1991:22). Up to this juncture it was not possible to ascertain exactly how many patients were in treatment at any given time, or how many prescribers or community pharmacists were involved in the provision of MMT (O'Connor 2002:22). Methadone had previously been prescribed as liquid Physeptone and could be dispensed in any chemist. The *Report of the Methadone Treatment Services Review Group* (DOHC 1997) recommended a change in the way methadone should be prescribed and dispensed in Ireland. The existing *Misuse of Drugs Act 1997 (S.I.12)* was amended to reflect these recommendations (*S.I. 308 1997, S.I.225 1998*). This obligated GPs to have undergone a period of training before they could prescribe methadone and required collation of information about all patients treated on a central register (Cahill *et al* 2003). Dispensing arrangements also changed and pharmacists could only dispense methadone to those who had a valid drug treatment card.

The pharmacological intervention of methadone was supported from the outset by the Irish College of General Practitioners (ICGP) (NAS 1992). The ICGP is the professional body responsible for accreditation and training of general practitioners. The role of general practice in the treatment of heroin addiction was advocated by a number of key GPs in the RoI (Farrell *et al* 2000:9). GPs were concerned about dubious prescribing practices of methadone by unscrupulous doctors and a

small minority encouraged the development of a greater role in the treatment of drug misuse at community level (Delargy 2000, Farrell *et al* 2000). A formal protocol for methadone prescribing was published in 1993 (DOH 1993). The ICGP issued guidelines on the management of drug misuse in 1997 (Cullen *et al* 2000). In October 1998 the Methadone Protocol Scheme (MPS) was initiated to provide a framework for the care of opiate misusers in general practice (ICGP 2002). Updated guidelines *Working with Opiate Users in Community Based Primary Care* were published in 2003 and again in 2008 (ICGP 2003, 2008). The format for both how methadone is regulated and how opiate dependant patients are managed in the RoI is now commonly known as the Methadone Treatment Protocol (MTP) (ICGP 2008).

The ICGP provides Level One and Level Two training for GPs in how to treat these opiate misusers (Appendix 2). This is a unique system of training which previously facilitated a multidisciplinary team approach to care involving professionals such as pharmacists, psychologists, practice nurses and midwives who attended the course together, albeit on an ad-hoc basis. Since 2008 this training has been provided for GPs only as an online learning format. This is in contrast to the UK, where the Royal College of General Practitioners (RCGP) advocates that treatment of drug misusers is multifaceted and normally requires a multidisciplinary response wherever possible. Training is provided in collaboration with practice nurses, dispensing pharmacists, practitioners with a special interest and addiction specialists (Ford *et al* 2005). In the RoI there has been an absence of organizational drive in recognizing this multidisciplinary approach and a lack of targeted resources from the nursing profession (Wilkinson & Mistral 2003). As with other countries a lack of clear development pathways or support systems for practice nurses in this regard has impeded addiction related education and the academic pathways have been unclear (Deering 2008). Pharmacists

also have been impeded by the lack of multidisciplinary training initiatives (O'Connor 2002).

Methadone maintenance is provided by the National Drug Treatment Centre (NDTC), Health Service Executive (HSE) addiction clinics and satellite community clinics and GPs. There were approximately 14,452 opiate misusers aged from 15-64 in 2001 (Kelly *et al* 2004). This capture/recapture study identified the rate of 5.6 opiate misusers per 1,000 of population within a population of approximately 4.4 million, similar to previous estimates (Comiskey & Barry 2001, Kelly *et al* 2004). The majority of these are resident in the greater Dublin area. Prevalence of recent drug misuse (use in last year) increased from 5.6% in 2002/03 to 7.2% in 2006/07 among all adults aged 15–64 (NACD 2006/2007). There are approximately 8,000 clients receiving methadone in the Republic of Ireland and almost one-third (32%) of opiate misusers currently prescribed methadone substitution are cared for in general practice (Delargy 2008). The number fluctuates as for example, in 2007, 9,756 received methadone treatment during the course of the year, while approximately 8,500 were in receipt of treatment in any particular week (NDS interim report 2009:43). The protocol offers a structured yet flexible approach to care and approximately 300 GPs are currently providing treatment in the RoI. Other substitution therapies such as buprenorphine are not available within general practice as yet although the National Advisory Committee on Drugs have called for a range of options to be made available to both drug misusers and practitioners recognising that together they should decide the most appropriate course of treatment for the individual (NACD 2003). The service, training requirements, accreditation criteria and payment structure of the MTP has in the most part been primary care led which has advantages and disadvantages (Farrell *et al* 2000).

The field of drug misuse treatment has traditionally been influenced by much moral discourse (Fry *et al* 2005) and although the MTP has been devised without explicit involvement from those who avail of this service-the service user, GPs have had the opportunity to proffer their views on this treatment modality as a method of harm reduction.

1.2. VIEWPOINTS OF GENERAL PRACTITIONERS ON METHADONE TREATMENT

Prejudices about drug misusing individuals and the use of methadone as a treatment option or as harm reduction are sometimes based on the premise that methadone treatment simply replaces one drug of dependency with another. The attitudes of professionals whether they accept this hypothesis or reject it may affect care and indeed how services have developed historically. All health care is currently informed by such institutional values and how health care is organized influences treatment effectiveness (Farrell 2004). Keane (2005) asserts that it is the rejection of moral judgment that has made harm reduction such an effective and innovative strategy. The European Methadone Guidelines advocate assessment of the quality of the service provided, acknowledging that the way in which treatment is offered is important for its outcome (Vertser & Buning 2000). These guidelines also acknowledge differences in historical, cultural, social, economic and political backgrounds across Europe and state that 'every community needs to reach its own consensus' for good clinical practice in methadone treatment. What good clinical practice means and how it is delivered is a subject which is inevitably linked to professional attitudes. The implications of negative attitudes towards drug misusers could be important in uncovering moral assumptions that may influence treatment (Norman 2001, Latham 2003). From the viewpoint of the 'conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett *et al*

1996), the decision to carry out methadone maintenance is one which is inevitably based on the physician's personal ethical stance. Harm reduction has been described as carrying 'connotations of permissiveness', conversely in the field of medicine it is often seen as the default approach (Deluca 2000). There are multiple interpretations that can be proffered as to why a physician is likely to either get involved with or avoid treating drug misusing patients. There are those who oppose the ethical imperative for the prescription of methadone (Fitzpatrick 2001, Grehan 2007), proponents who advocate methadone as a scientifically proven and ethically approved intervention for a chronic, potentially fatal illness (Latham 2004) and those who oppose the role of doctors in the regulation of lifestyle and individual patient behaviour (Fisher 2004). Some cite barriers such as the lack of training and fear of practice disruption as reasons for not getting involved (Miller *et al* 2001, Mc Keown *et al* 2003, Keen *et al* 2004, Turner *et al* 2005). Merrill and Ruben (2000) assert that lack of training, knowledge and experience of GPs in managing drug misuse is pertinent both to why GPs are averse to prescribing, and why drug misusers are disinclined to seek treatment from their GPs.

One of the few studies which explored GPs' attitudes towards the use of MMT was conducted in general practice in the RoI (Wilkinson & Mistral 2003). Survey and interview methods were combined and a questionnaire was sent to all of the 275 GPs registered with the methadone scheme, plus a further 100 GPs selected at random from the register of GPs held by the ICGP who were not prescribing. While the majority of GPs who were prescribing methadone strongly agreed that many benefits were obtained for the service users, 70% of those who did not prescribe felt that all problem drug misusers should be referred to specialists and were strongly unwilling to take on methadone maintenance clients. They anticipated problems with patients' behaviour and disruption to their practice. There was a 63% (n=236) return rate,

63% (n=173) from GPs who were prescribing and 63% (n=63) from the GPs who were not prescribing. This was a return rate similar to a study of GPs treating drug misusers in Scotland (McKeown *et al* 2003). Qualitative interviews with 28 GPs who were not prescribing, explored issues raised by the survey. Those not prescribing were less convinced of the merits of MMT than their counterparts. Disparaging comments were made about doctors who were on the scheme, with regard to competency and financial motives for prescribing. Some described patients as being 'dirty and smelly', likely to 'offend other patients' or hanging around the surgery bringing the practice into disrepute. The overall picture that emerged from GPs responses was that GPs who were prescribing were positive about the benefits of methadone; however only half viewed the training as adequate. Although the interview material was biased towards those prescribing methadone, the responses from these GPs indicated concerns about clinical policies and procedures for dealing with 'dirty urines' and a wish for more flexibility of practice. The detailed responses and written comments by GPs both prescribing methadone and those who were not, have important implications for the future of services for drug misusers and this was an important study which laid a foundation for further research with GPs.

A more recent study conducted by postal survey explored GPs subsequent attitudes to the MTP. The survey was sent to the 600 GPs on the ICGP drugs' misuse database who had ever attended for substance misuse training (Delargy 2008). Of the 600 questionnaires sent 207 responses were received. A response rate of (34.5%) was documented. The questionnaire was designed to identify what barriers existed to accepting patients for treatment. The majority of respondents 72% (n=149) already had patients on the MTP at that time while less than a third 28% (n=58) did not. Attitudes which focused on the benefits of MMT suggested that, similar to the study by Wilkinson and Mistral

(2003), GPs overwhelmingly believed that it was now an essential service to drug misusers 95% (n=197). Furthermore the majority 96% (n=199) felt that the structure of the MTP provided a regular opportunity to review patients' progress and to allow a good relationship with the patient (Delargy 2008). The report concluded that most GPs who had presented for Level I training showed an 'untapped willingness' to participate in the programme if requested. The responders' attitudes reflected concern about the problems of illicit drug taking among their practice population. Results from postal questionnaires should be interpreted cautiously and in this study the response rate was low (Edwards 2001) with no documentation as to how these results were validated and statistically interpreted. In the absence of other research, this survey was useful for gaining cautious insight into the recent attitudes of GPs in the RoI. However as they had all participated in training, bias can not be excluded.

There have been other criticisms in relation to GP involvement in MMT in the RoI. Barry (2002) when reviewing the tackling of opioid misuse over the past two decades stated that although GPs were identified as a key group in terms of implementing harm reduction, it took five years, the production of two policy documents on methadone prescribing in general practice (DOH 1991, DOHC 1997), a change in the law, negotiation of a generous remuneration package for GPs and the development of a network of health board satellite clinics and addiction centres and supports, before it got to the stage where 25% of GPs (there are approximately 2,500 in the RoI) in Dublin took part in the MTP. There are several other ethical and sociological viewpoints which challenge a number of the bio-medical assumptions regarding the delivery of MMT.

1.3. GENERAL SOCIOLOGICAL AND PUBLIC HEALTH ISSUES OF METHADONE TREATMENT

In spite of GPs attitudes, there are those who feel it is imperative to challenge the current status of such treatment as methadone maintenance and declare it as a biomedical and public health paradigm which should be subject to scrutiny (Ning 2005). Foucault (1926-84), a French philosopher, sociologist, and historian claimed that knowledge and power are interconnected. He suggested that discipline through imposing precise norms is pervasive in society; therefore the idea of regulatory technology which aims to create productive and obedient subjects (such as those on MMT) presents an opportunity for control (Keane 2009). Bourgois in a somewhat similar sociological stance describes advocating MMT as representative of the state's attempt to inculcate moral discipline into the hearts, minds, and bodies of deviants who reject sobriety and economic productivity (Bourgois 2000:167). He uses the concept of bio-power (a term originally coined by Foucault to describe state control and regulation of subjects) to reveal how the disciplining of patients takes place in a methadone clinic. He believes that methadone maintenance forces heroin addicts to comply with bio-medical and public safety goals (Ning 2005:360).

Weinberg (2000:617) in his research into the sociology of health and illness also introduces challenges in that he argues that the tenet that drug addiction is a 'bona fide disease' has been historically constructed and this idea has been crucial in campaigns to promote therapeutic interventions (such as MMT) at the level of public policy. Using this theory to foster solutions he suggests that the symptoms of addiction should be identified before solutions can be sought. He proposes a more sociologically incisive response to addiction which rejects biological reductionism (Weinberg 2002). There have also been criticisms leveled by doctors at the utopian biomedical gaze which

pursues the problematisation of normality and views patients as “unhealthy” if they are not compliant with accepted norms of treatment and thus in need of medical intervention. A bio-medical model which views any deviation from perfection as pathology needing treatment denies the sociological determinants of health (Misselbrook 2010).

However there are public health issues associated with addiction and the disease model which can not be ignored and influence service provision. To date MMT has almost certainly been instrumental in maintaining relatively low rates of human immunodeficiency virus (HIV) sero-prevalence among injecting drug misusers worldwide and in Ireland (HPSC 2007). MMT, as stated earlier, is effective in the reduction of heroin use, drug related mortality, and crime (Ward 2002). The impact of MMT on hepatitis C virus (HCV) transmission rates however is unknown as HCV prevention science is in its infancy and it is unknown what intervention works best (Mateu-Gelabert *et al* 2007). Approximately 75% of the intravenous drug misusing population in Dublin are infected with HCV and 56% are PCR positive (Kavanagh *et al* 2003, Cullen *et al* 2003). Demonstrating with certainty that programmes that facilitate safe injecting have reduced the occurrence of HCV, has proved elusive (Jones *et al* 2008) and screening in the RoI has been identified as being inconsistent with lack of co-ordination between primary care providers, addiction treatment centres and hepatology services (Smyth *et al* 2000, Cullen *et al* 2007). This situation is borne out in other studies, for example Canada where there are extremely low rates of HCV treatment initiation (Grebely *et al* 2009).

From a sociological perspective, public health concerns such as these and harm reduction policies have been identified as ‘parallel social movements’ (Rhodes 2002:85). Treatment has social as well as public

health and medical components, and identifying these social processes has been deemed important for the delivery and effectiveness of MMT. Ning (2005) produced ethnographic examples from interviews with service users (n=40) and staff (n=4 staff) within a methadone clinic in Toronto (the team comprised a physician, pharmacist, counsellors, case managers, nurse, drug screening technicians, and administrative and support staff). Staff and service users described the complex workings of power, whereby neither staff nor service user was exclusively dominant or exclusively resistant to domination. Service users were not mere victims subject to the regulatory bio-power of the methadone clinic as suggested by Burgois (2000) but rather were able to make tactical responses and negotiate treatment. This work identified that focusing on therapeutic interventions alone may preclude a deeper vision of the social dynamics at work in treatment settings. Different individuals were deemed to have different treatment needs—needs that may or may not have coincided with the expectations of the methadone treatment programme.

Holt (2007) theorizes that drug dependence should be viewed primarily as a social rather than a health problem. He presented ethnographic examples of the lived experience of 77 drug misusers, examining their experiences of MMT and that of receiving prescribed medications for depression in methadone clinics. Drug treatment services were delivered either privately or in a public institution in both metropolitan and regional areas of Australia. He suggested that service users exercise agency while at the same time find their ability to act curtailed by the strictures of treatment itself. The recourse to negotiation was deemed an inevitable response by those receiving methadone who were trying to adapt to imperfect treatment conditions. He saw this as constituting a failure to explain the need for treatment, its consequences, and how clients might manage unexpected or unwanted

treatment effects. An apparent change in status from 'autonomous agent' to 'participant in treatment' occurred suggesting that part of substitution treatments' desirability is the perception that clients relinquish the freedom to pursue a drug-using lifestyle and instead willingly participate in treatment (where, by implication, they are subject to greater oversight and have less freedom to act autonomously). The premise is that participation in treatment ties service users to regulations and reduces their capacity for independent action.

Lilly *et al* (2000) reporting on findings from a two year ethnographic study of methadone treatment delivery in London explored the 'sociality' of treatment as being embedded within the negotiation and building of social roles and relationships. The study sites were two drug dependency units and clients receiving a 'shared care' treatment model with GPs at a specialist drugs service where staff co-managed the client. Forty interviews were conducted with professionals and 45 clients were interviewed. They described the experience of delivering and receiving methadone treatment as a social process, involving social interaction between the service provider who is a conduit through which 'treatment' is delivered and service user who is the recipient. The necessity of understanding the delivery of methadone treatment services as a social inter-actional process and not merely as a medical encounter with a treatment outcome, highlights the practical implications of understanding other factors associated with methadone treatment. The provision of methadone without understanding the dynamics of the treatment environment undermines the concept of holistic care and treatment effectiveness.

Agar *et al* (2001:76) criticized methadone as a drug which has clouded the boundary between treatment and the streets and as such has accommodated an addict's world. "Treatment" means taking an opiate, rather than requiring that opiate use cease before treatment is started. In this respect, compared to any other drug-free treatment, they

suggested it has become easier for the service user to experience treatment within the context of the “patient” role.

There is also the view that methadone creates some privileges such as stability but at the cost of surrender and domination, invoking the metaphor of the “liquid handcuffs” of treatment. The analogy of “swapping the dealer for the doctor” and still being tied to an addictive drug, has been proffered by those on treatment. This description is accepted by many. Binaries such as these have been discussed in the work of Friedman and Alicea’s (2001) *Surviving Heroin* who claimed their work was a much needed corrective to the narrow stereotype promoted by clinicians (Broadhead 2002). Willingness to seek out professional help and by so doing following the treatment prescripts of medicine infers a structured and normalizing existence which is acceptable to many treatment providers who may not question this bio-medical approach.

A more complex understanding of methadone as a material which has become a socio-cultural phenomenon has been presented by Fraser and Valentine (2008) in their book *Substance and Substitution*. It combines interviews (with clients, prescribers, health workers and policy makers) with analyses of media representations, medical literature and policy documents. They argue that the split between the social and medical, between the chemical and psychological facets of addiction are often enmeshed in the experience of clients. They caution that treating MMT as the provision of a drug and little else entails a narrow view of the problem. Methadone treatment allows service users a degree of autonomy from the demands of an illicit drug using way of life but it simultaneously can impose a regime that is equally, or more controlling. Keane (2009) when critiquing this work explains that the substance of methadone is described as a phenomenon which needs

explanation rather than existing as a stable entity upon which the politics of MMT is erected. The treatment identities which can be created by MMT were also explored in this work and this finding has resonance with other studies (McIntosh & McKeganey 2000). Fraser and Valentine further explore the discourse about methadone and recognize the political, cultural and social issues which arise when the problem of drug misuse is perceived as one of deviance. Although the role of politics and culture in shaping and provoking methadone treatment has been discussed with certain skepticism in the literature, these issues can not be explored in isolation.

Rhodes (2002) advocates an approach to harm reduction which considers factors such as those influenced by context. A risk-environment approach to drug research, policy and practice, highlights the parallels and connections in how context influences health and vulnerability in general as well as drug-related harm specifically (Rhodes *et al* 2003, Rhodes *et al* 2005). Rhodes (2009:199) further delineates that 'a risk environment approach is a social science for harm reduction which acts first to reduce social suffering'. Addiction is recognized by some GPs as a chronic relapsing condition which creates social suffering and it is also well recognized that GPs have a pivotal role to play in the management of chronic disease (Keen *et al* 2004, Dennis & Scott 2007, Luty & Sujaa 2008, Latham 2010). The primary focus of harm reduction intervention policies has been centred on individual risk behaviour change (Rhodes 2002), but international research has repeatedly highlighted the role of environmental-contextual factors in limiting the ability of drug misusers to embrace individual behaviour change in order to reduce drug-related harm (Moore & Dietze 2005). Weinberg (2002) argues that drugs are used in ways that are always personally meaningful to drug misusers and this

meaningful use of drugs is always embedded in, and at least to some extent, practically responsive to, socially structured contexts of action. Criticisms arise when faced with the problems that occur when focus on the individual is at the expense of the community and creates an inherent imbalance. Reconciling both individual and community health is a feature of general practice in urban disadvantaged communities and balancing the focus between individual, geographical and social factors can prove difficult (Peckham 2004). One instance of this is acknowledging that the local level drug dealing environment is an important feature of local economies in marginalised communities and sharp distinctions between users and dealers are not always easy to identify (Fitzgerald 2009). Each community has its own specific environmental factors which influence harm and these factors can not be generalized.

These disparate viewpoints and argument in the literature identify that there are various well accepted merits associated with MMT however its value is compromised by the experience of service users which may not always be considered important within the bio-medical approach. While there are enormous challenges such as these in our understanding of MMT, important “indicators of success” in managing and treating drug misusers have been identified such as retention in treatment, both while the person is in treatment and as a predictor of what is likely to happen after they have left treatment (Caplehorn *et al* 1994, Gossop *et al* 2001). These indicators of success are identified in the literature as measures of “treatment effectiveness” from the focus of service providers rather than the documented perceptions of service users.

1.4. MEASURING AND MAINTAINING EFFECTIVE TREATMENT

Studies focusing on client retention and treatment duration have been criticized as limited if they fail to take account of issues relating to the social component of treatment delivery (Lily *et al* 2000). However in the United Kingdom (UK), the National Treatment Agency for Substance Misuse (NTA) considers retention to be the best available measure of drug treatment effectiveness (Beynon *et al* 2008). Irish retention rates in methadone treatment are impressive (Cox *et al* 2007) in comparison with England, Scotland and Australia (Gossop *et al* 2000, Darke *et al*, 2005, Morris & McKeganey 2006). What influences retention is purported to be related to the dose of methadone not the provision of ancillary services. For example a meta-analysis of studies comparing the provision of methadone maintenance with and without ancillary services demonstrated decreased illicit heroin use with ancillary services but found no statistically significant additional benefit in terms of retention in treatment, RR 0.94 (95% CI, 0.85 to 1.02) (Amato *et al* 2005). An observational study of 351 patients in the UK receiving methadone maintenance compared with those receiving methadone dose reduction found the following retention rates: 88% vs. 86 % at one month, 71% vs. 58% at two months, 62 % vs. 50% at one year, and 42% vs. 30 % at two years (Gossop *et al* 2001).

How long an individual spends in particular treatment however is also contingent on contextual factors such as the constraints of the programme they enter (Lilly *et al* 2000, Moore & Dietze 2005, Morris & McKeganey 2006) the relationship with the prescriber (Wilkinson & Mistral 2003), dosage levels, and the philosophy of care. Patients retained on MMT for one year in a primary care setting in Sheffield which is a specific primary care clinic developed to support GPs, have been shown to achieve improvements on a range of harm reduction outcomes similar to those shown by studies in other, often more highly

structured programmes (Keene *et al* 2003). The philosophy of the clinic which offers a full range of community based treatments for drug misusers is to face the reality of heroin addiction without damaging the morale of service users by setting unrealistic goals such as abstinence.

There are limited studies which investigate the effect of drug treatment and retention rates in the RoI. One of the few, the first National prospective longitudinal multi-site drug treatment outcome study (ROSIE) was published in 2006 (Cox *et al*). This observational study evaluated drug treatment effectiveness for 404 opiate users entering treatment for the first time or returning to treatment after a period of abstinence from treatment. Treatment was conducted either as an inpatient in hospital, a residential programme, or in prison; out-patient settings were community based clinics, health boards or GPs. At one year follow up there were 305 respondents. Treatment modalities were: methadone maintenance/reduction 53% (n=215), structured detoxification 20% (n=81) and abstinence based treatment 20.3% (n=82). The interview schedule focused on data such as drug usage in the previous 90 days preceding the interview. Positive outcomes were significant reductions in heroin use from 81% at treatment intake to 48% at one year, and frequency of use from an average of 42.6 days out of 90 at treatment intake to 15.8 at one year. Other illicit drug misuse was also reduced. The three year follow up published in 2008 identified that behavioural changes were sustained over time (ADRU 2008). The number of those selling/supplying drugs fell from 30% to 13% and the number handling stolen goods fell from 25% to 10%. Once initial improvements were achieved between intake and 1-year, it seems that participants experienced a period of stabilisation with respect to criminal activity and this outcome did not change significantly between 1 and 3 years. There were reductions in the proportions of participants who reported use of non prescribed methadone, cocaine powder, crack

cocaine, cannabis, alcohol and non prescribed benzodiazepines at one year compared to the baseline interview. These reduced levels were maintained between one year and three years for all drugs except benzodiazepines (Drugnet 2008). It was observed that 38% of the participants recruited in methadone were still in their intake treatment setting at 3-years. This study suggests that involvement in drug treatment programmes has a positive impact on individuals. The findings did not indicate causal relationships between the treatment received and the outcomes observed such as behavioural change. The study did not randomly allocate participants to treatment settings or modality, nor did it employ a control group (i.e. drug misusers with similar profiles not attending the treatment). In addition the geographical locations of the services chosen reflect the provision of services available at national level rather than being a representative sample (Cox *et al* 2007). While longitudinal quantitative studies such as ROSIE may identify relationships between variables, these studies can not explore the complexities or dynamics within such relationships, nor can they explain the meaning behind the correlations. Behavioural change may be due to the interaction of three factors: the person, the environment, and the intervention, all of which can influence outcomes; there is no evidence from the study to suggest what particular intervention “works” from the service users’ perspective and the factors that influence positive treatment responses were not identified.

The narrowness of the medical model of outcome measurement may not sit well with service users’ views of what constitutes treatment effectiveness and it is important to identify other factors which influence change. Methadone maintenance is a successful management tool; however there are factors which limit its effectiveness such as variability of treatment programmes (Rettig *et al* 1995). Treatment effectiveness has been shown to be related to patient motivation; problem severity;

therapeutic engagement; and intensity of services; as well as linkages to community-based social supports (Simpson 2003). Treatment and retention are interlinked and may be influenced by professional attitudes towards drug misusers which may in turn have an important influence on how clinical guidelines are implemented. As identified earlier, the assumptions surrounding treatment for addiction have been medicalised (Burgois 2000, Weinberg 2000, Weinberg 2002, Holt 2007) and this model appears to exist in a vacuum whereby environment and contextual factors are often ignored.

Regardless of the fact that retention in treatment is linked to reduction in risk behaviour, as substantial lifestyle changes are sustained over time, it is important to appreciate that this may not be the service users' goal (Chalmers *et al* 2007). Participants on methadone programmes are not always willing to commit to indefinite maintenance but would have preferences for shorter time-limited methadone treatment (McKeganey *et al* 2004, Peterson *et al* 2010). Indeed Farrell *et al* (2000:10) in his review of treatment services in Dublin suggested a twin track approach that combines detoxification with maintenance which would ensure some individuals could have shorter term contact with services and would create some treatment capacity by creating a degree of throughput for one stream of patients.

There are other significant problems with MMT such as concurrent benzodiazepine misuse, which has historically been a significant issue among clients in treatment clinics in Dublin (Corrigan 1986, Hindler *et al* 1996, Farrell *et al* 2000). This situation remains a major concern for general practice in the context of MMT (Farrell *et al* 1994, DOHC 2002). Prescription and over-the-counter medications have been implicated in many poisoning deaths and benzodiazepines, often in conjunction with an illicit substance, have been implicated in more deaths than any other drug in Ireland (Lyons *et al* 2008). The impact of this type of drug needs

to be addressed within treatment and prevention services. A systematic review of treatment approaches to dose reduction strategies for benzodiazepine dependence was carried out in general practice and out-patient settings in Australia (Parr *et al* 2009). Routine care was compared with three treatment approaches: brief interventions, gradual dose reduction (GDR) and psychological interventions. GDR was compared with GDR plus psychological interventions or substitutive pharmacotherapies. The nature of treatment offered proved to be important and raising the issue of discontinuation at every consultation increased the likelihood of ceasing use successfully. Little focus has been placed on interventions necessary to facilitate this approach within general practice in relation to the orthodox intervention of methadone. Engaging with those who have been marginalized due to addiction is a particular challenge for inner city primary care (RCGP 2005) and working in partnership with a drug misusing patient involves not only the individual but also parents, children, relatives, child care agencies and drug treatment agencies coupled with an overall commitment to support and enhance family relationships and skills (Clarke 1994). Understanding how the concept of partnership and relationship building affects treatment for the individual on MMT may prove useful for improving the harm reduction praxis of methadone treatment in general practice.

1.5. THE ROLE OF PARTNERSHIP AND RELATIONSHIP BUILDING IN METHADONE TREATMENT?

Historically there has been a paternalistic approach to patient care which arguably has impeded the building of relationships between health care providers and service users (Coulter 1999). Increasingly however, partnership models of health care have been advocated and enshrined in current international healthcare policy (Duncan *et al* 2010).

Indeed in many treatment plans in primary care, outside of the addictions' field the involvement of patients and patient groups is the norm (Rhodes *et al* 2002, Greenhalgh 2009). Partnership models of care have been advocated in several chronic disease management guidelines such as diabetes (DoH 2005) and many other long term conditions yet patients' views have seldom been sought regarding how chronic illness is managed (Cooper *et al* 2003). The expert patient initiative was launched in 2002 in the UK which embodied the idea of a much more active patient, and of a patient centred health care system, thus reducing the power of professionals and superseding the original paternalistic approach.

Even before this, understanding that the patient is “expert” was identified as crucial to the role of effective care in general practice (Balint 1964). Current evidence suggests however that shared decision-making has not yet been widely adopted by health professionals and significant barriers exist. Gravel *et al* (2006) carried out a systematic review of healthcare professionals' perceptions of shared decision making. Perceived negatives identified were time constraints, lack of applicability due to patient characteristics and lack of applicability due to the clinical situation. Positives identified were provider motivation, beneficial impact on the clinical process, and effective impact on patient outcomes. They concluded that interventions to foster implementation of shared decision-making in clinical practice need to address a broad range of factors. They also identified that the majority of published studies originated from the UK and the USA which suggests a proactive approach to research in the area of shared decision making.

The RoI has lagged significantly in this area and the ICGP has only recently published the *Partnership with Patients Report* (ní Riain & Dempsey 2009:1). This states that ‘the focus of the ICGP is consistent

with the patient-centred approach of the Irish National Health strategy *Quality and Fairness—A Health System for you* (2001) and *Primary Care—A New Direction* (2001) and reflects the need to involve the knowledgeable patient in building a safer health system described in *The National Strategy for Service User Involvement in the Irish Health Service* (2008 – 2013) and the *Report of the Commission on Patient Safety and Quality Assurance* (2008). Drug treatment strategies are absent in these reports.

The complexity of patient participation is that both practitioner and service user might offer differing perspectives on what this participation constitutes and what role partnership plays in decision making and specifically how that translates to the management of drug misuse. The individual is the central focus of the GP consultation and the significance of partnership and relationship development between this individual and his or her GP has been an overlooked dimension in addiction research. There is evidence to demonstrate that primary care can effectively contribute to individual health (Peckham & Exworthy 2003) and the ICGP advocate that the GPs' unique knowledge of the patient and their extended family can make a considerable contribution to the long term management of those receiving methadone (ICGP 2008).

A more useful concept of partnership from the perspective of the service user may be to understand the process by which service users and physicians attitudes and behaviour facilitate decision making, negotiation and sharing control. Sharing control and shared decision making is a partnership approach between service provider and service user which acknowledges "relationship" as key to the process. This concept of personal relationship between practitioner and patient alike has been viewed as having a pivotal role in general practice (Stokes *et*

al 2004). This relationship has been described as unique, established 'on the basis of mutual satisfaction and mutual frustration' (Balint 1964: 249). The power issues inherent in the roles of prescriber and recipient of methadone complicate this relationship and can militate against an equal system of partnership. Criticisms of this type of relationship exist as Bourgois *et al* (1997:155) state that social suffering is inevitably viewed 'through a theoretical lens that privileges power'.

Physicians' attitudes have been identified as barriers to informed and shared decision making (ISDM) and a major barrier to the practice of ISDM by motivated physicians appears to be the need to change well-established patterns of communication with patients (Towle *et al* 2006). Recent research in general practice has identified the importance of GPs eliciting the triad of ideas, concerns, and expectations (ICE) in the general practice consultation which has a potential impact on medication prescribing (Matthys *et al* 2009). These ICE components are highlighted as key competencies related to shared decision making, especially when deciding whether to prescribe medication. Additional expertise is required when that medication involves treatment for drug misuse.

There has however been little emphasis placed on any aspect of partnership or relationship building in general practice in the RoI. A recent qualitative study involving thirty Irish GP trainers highlighted the GPs relationship with what the investigators termed a 'heart lift' as opposed to the phrase 'heart sink' patient (O'Riordan *et al* 2008). Among questions posed to the GPs the question of *Tell me about a patient you like?* elicited three themes: easy to like, a challenge, and the necessity to renegotiate the doctor-patient relationship. When describing a lady in her 30's who was prescribed methadone, one GP expressed the following; she was *singularly the most difficult patient I've ever come across*: their relationship had 'deteriorated' and *she felt I*

didn't care. She's the only person that has told me ...I really failed them.

This led to an explicit renegotiation of the relationship: *The patient stopped her drug misuse, she y'know is a delight.*

When the GPs were also asked- *what have you learned about yourself as a GP?* one theme elicited was the GPs role *as a facilitator of sometimes chaotic and difficult lives*. This study was not specifically aimed at GPs' responses to drug misusing patients in its original intention however it does offer narratives which are useful for reflecting on the importance of the doctor-patient relationship with patients who challenge their assumptions. The authors addressed the limitations of the study claiming there was a risk of social desirability bias as the decision to restrict the study to trainers may have meant that a snapshot of an unusually reflective minority was gained, which may not have been reflected in the wider GP community. It is interesting that the assumption made by the medical profession regarding "chaotic use" infers that chaos is constituted as self-evidently bad and the opposite of order and stability. The intrinsically "chaotic user" has thus partially been defined by his or her inability to enact or inhabit stability. This view has been frequently accepted in drug misuse discourse and these attitudes have the potential to undermine relationship building. Fraser and Moore (2008) suggest that blanket assumptions such as these pose the risk of failing to grasp fully the dynamics of drug misuse, and importantly, some of the reasons why harm reduction measures are not always adopted by drug misusers. O'Riordan *et al* (2008) concluded that the process of relationship building can be enhanced by education and support such as reflective learning, teaching and training for all (Anderson *et al* 2003).

Understanding the significance of the doctor-patient relationship may be central to exploring who controls the intervention of MMT in general practice. Improving the doctor-patient relationship is challenging and fear and lack of expertise in how to deal with drug related problems can

affect this relationship. Fraser and Valentine (2008:19) describe how very privileged professionals have been traumatised by their experience of providing methadone treatment and they themselves have been subject to serious anxiety, possible danger and isolation in their work with service users. Neale (1999:143) recognized that social workers also, although familiar with working in partnership with other agencies, and trained to make connections between personal troubles and the broader social factors involved in client problems, sometimes feel that they do not have sufficient resources to deal with complex problems. Taking account of the broader family and social circumstances of the individual in a one-to-one consultation is complex and meeting the needs of drug using parents and their children has been described as a formidable challenge (McKeganey *et al* 2002). In Dublin the rehabilitation process associated with drug addiction has been described as prolonged, raising many childcare issues for professionals (Quigley 2002). Effective and intuitive consultation is at the heart of good practice and the ability to engage in a facilitative rather than autocratic manner has been advocated in many models of consultation (Pendelton 1984, Neighbour 1987, Kurtz *et al* 1998). Treating drug misusers with respect, listening to their concerns and those of their families has been actively desired and highlighted by drug misusers themselves as crucial to their treatment (Fischer *et al* 2007).

Other issues which may arise in the consultation are those which involve change and the formation of identity. Drug misusers' experiences of recovery from heroin addiction and the desire for a new identity and a different style of life were evident in a study carried out by McIntosh and McKeganey (2001). They conducted 70 semi-structured interviews with recovering addicts in Scotland and these accounts consistently described a process of trying to recover or repair what they experienced as a "spoiled identity" as a result of drug addiction. The

need for training in the area of identity formation and change was recognized in this study. It is true that few people make an immediate and once-only transition from drug misuse to abstinence (McKeganey *et al* 2004). Redefining the “sense of self” and reconstructing the identity of the recovering drug misuser has been identified as a process which requires experienced care (Etherington 2008). How that process of transition is facilitated in general practice and how users’ experiences of methadone treatment services influence individuation, recovery and the formation of identity has had limited research focus. It is uncertain what training is required to address this process of recovery in treatment from the perspective of the user. Mistral and Velleman (2001) surveyed GP’s in Wiltshire and suggested that carefully focused education, training and support could increase effectiveness for the service user on MMT. However this was only if the primary care practitioners were willing. Taking into account the service user’s perspective might support identity formation leading to some improved outcome for the patient on MMT. Factors that impact on retention and therapeutic engagement such as the relationship between patient outcomes and elements of the therapeutic process-namely the treatment environment, patient needs, and delivery of services should be addressed in the consultation (Simpson *et al* 1997). While practical approaches to care are extremely important there are other aspects to the therapeutic relationship and patient participation which require negotiation with patients in relation to a range of issues (Haidet *et al* 2006). There is no doubt that therapeutic commitment is required when working with those addicted to drugs. What is regarded as therapeutic and a desirable result by the service provider may be viewed less favourably by the service user. Service user for the purpose of this study is defined as the individual who is receiving the intervention of methadone maintenance in the setting of general practice. Achieving a therapeutic effect may require a high degree of physician and patient negotiation and a process of

engagement with service users which has hitherto been noticeable by its absence.

1.6. SERVICE USERS' VIEWS OF METHADONE TREATMENT

Opiate users' views of methadone treatment have been investigated internationally although most of these studies have been focused within specialist treatment centres (Fischer *et al* 2002, 2007, 2008, Gourlay *et al* 2005, March Cerda *et al* 2006, Madden *et al* 2008). March Cerda *et al* (2006) explored the views of 30 service users about their methadone treatment programme. This was provided at drug treatment centres located in Barcelona and Granada. The care provided by therapeutic teams relied on three main intervention areas: medical, psychological and social care. Despite the generally positive outcomes of MMT expressed, its main limitation lay in the lack of a comprehensive approach to users' individual needs. Strengthening bio-psychosocial intervention emerged as an essential prerequisite to progress towards users' rehabilitation. Madden *et al* (2008) surveyed 432 clients receiving treatment at 9 public clinics in New South Wales, Australia. Client perceptions were assessed across a number of treatment domains, the clinic environment; service provision; clinical relationships; medication; and treatment outcomes. Participants reported being 'mainly satisfied' with their treatment but caution was expressed as to what a consumer reasonably expects to receive from a service, as issues of treatment satisfaction can be dependant upon service users' 'expectations' and 'relative experience'. If service users have low-level expectations of quality and they receive a service which meets these criteria, they were considered likely to rate that service as 'acceptable'.

Attitudes of recipients (n=29) of unsupervised injectable opiate treatment (IOT) for opiate addiction were explored in two community drug teams in northwest England (Orgel *et al* 2009). Most of the

respondents' attitudes were positive describing personal and social benefits: reduction or cessation of illicit drug misuse; health gains; more normal lifestyle; and reduced criminal activity. Orgel concluded that IOT recipients were not a homogeneous group and had different needs and goals which needed to be voiced and heard. As recipient views have been in the most part neglected in the literature, in this work the individual voice was recognized as being crucial and adds to the debate about treatment effectiveness. A further small Australian study explored the experiences of stigma and programme regulation experienced by 10 service users (Gourlay *et al* 2005). Although a comprehensive approach to user's individual needs has been advocated in each of these studies none were carried out in general practice.

Fischer *et al* (2002) identified that service user conflict can result in a number of possible outcomes, including the premature termination of treatment; staff deciding on the appropriate outcome, the client appealing to the governance structure of the agency, brokered compromise, and staff skillfully eliciting client consent for staff decisions. Fischer *et al* (2007, 2008) have also highlighted the complexity of user involvement. Examining client/staff conflict and user involvement in drug misuse treatment decision-making they conducted 79 in-depth interviews with new treatment clients in 2 residential and 2 community drug treatment agencies. They identified that services are more likely to be successful if clients have some choice about, and involvement in deciding, what treatment/s they actually receive. They suggested that factors such as the perceived characteristics, needs and expectations of drug misusers, attitudes of professionals, the dynamics of treatment encounters, treatment programme design and structural factors affecting service provision all require consideration. They found that staff can deploy user involvement as a strategy for managing conflict and soliciting client compliance to treatment protocols. This was

a comprehensive study of both residential agencies and community agencies and the researchers acknowledged that many areas of user involvement were not addressed. Those involved in community agencies however valued flexibility, tailoring of services to meet individual needs and establishing effective channels of communication. Some critics feel that the result of promoting user involvement in drug treatment has weakened the users' voice and given health professionals the authority to define users' needs for them (Rhodes & Nocon 1998). Others have the opinion that user involvement brings with it a wealth of advantages ranging from quality assurance of service delivery, positive client outcomes, effectiveness and efficiency as well as higher morale for staff and wider support from agencies (Polley 1995). Policy analysts have stated that the knowledge held by service users can be critical in the effective crafting of strategy; their first-hand experience and understanding of the problems and of the solutions that work can feed into policy development processes appropriately (Pike 2008:106).

Neale advocates for an emphasis on users' views which is consistent with developments in many other service areas, particularly the focus on user rights, accountability, empowerment, choice, and participation (Neale 1999). She has conducted several studies exploring drug misusers' views of receiving methadone and the conditions attached to the prescribing process and contends that evaluations of methadone treatment from the users' perspective provide an important resource in both the substitute prescribing process and in other forms of professional interventions in the lives of drug misusers (Neale 1998 a & b, 1999 a & b).

Despite service users' emphasis on the necessity of their involvement in all parts of their treatment programme (Hunt 2002, Montagne 2002,

Murray 2005), the terms “user involvement” and “empowerment” have been expressed loosely and without precision in the literature. Government policy in the UK clearly states that those with drug problems should be involved in decisions relating to their own treatment. Service users however have had minimum representation and limited decision-making power at the level of policy formation (Zibbell 2004). There is also little evidence to support the effect of user involvement and decision making in drug services (McKeganey *et al* 2004, Nilsen 2006).

User involvement has been relatively slow to develop and there are differing opinions as to how user involvement impacts on service delivery (Fischer *et al* 2007). What empowerment means from the users’ experiences of methadone treatment services is therefore uncertain. Patient empowerment often means encompassing patient choice and a more collaborative approach between patients and professionals when it comes to making clinical decisions (Appelby & Dixon 2004). Treolar *et al* (2007) recommend the inclusion of service-user perspectives to ensure that services are not wrongly targeted and that evaluation of those services does not underestimate or misrepresent their value to clients. While service providers have made efforts to engage consumers in service planning and delivery these efforts appear to be ineffectual because of poor communication between providers and service users (Bryant *et al* 2008). There is little evidence that Irish service users needs and wishes have been actively sought in the field of substance misuse let alone their involvement in treatment programme design in the RoI.

1.7. METHADONE SERVICE USERS’ VIEWS IN IRELAND

Historically there has been limited experience in encouraging service user consensus viewpoints in the RoI and there is a scarcity of literature

pertaining to service users' views of methadone treatment in general practice. McEvoy *et al* (2008) when reviewing the literature for the *National Strategy for Service User Involvement in the Irish Health Service* (2008 -2013) suggested that some of the most provocative and intelligent discussions on service user involvement are to be found in literature that is outside the usual parameters of scientific databases and literature. Studies such as these, although small, portray largely negative reactions of service users to treatment programmes (O'Connor 2003, UISCE 2003, Lawless & Cox 2003, O'Reilly *et al* 2005, O'Reilly & O'Connell 2006, Ballymun Youth Action Project 2007-2008) and also negativity in relation to service provision (Wilkinson & Mistral 2003). Service user feedback in the RoI has been accused of being idiosyncratic, based on personal experience and needs rather than on the wider picture of service commissioning and delivery (Velleman *et al* 2001).

O'Connor (2003) in her doctoral thesis, examined patient satisfaction with the pharmaceutical aspect of methadone treatment services provided using both qualitative (combination of group and 15 individual interviews) and quantitative methods (a cross sectional survey of 217 participants). The findings from the study identified that although clients were pleased with the introduction of community pharmacy services there was tension in the pharmacist/patient relationship due to conflicting pharmacist attitudes and unequal power relations. O'Connor acknowledged limits to the generalisability of her findings due to her sampling methods.

The Union for Improved Services, Communication and Education for Service Users (UISCE) is historically one of the few users' forums which exist in Dublin. The group is composed of users, ex-users and professionals who believe that the voice of the drug misuser is integral

to the development of drug policy and in realizing an effective treatment response (O'Reilly *et al* 2005). UISCE collated the opinions and observations of north Dublin inner-city drug misusers receiving methadone in 2003. Both quantitative (survey) and qualitative (focus groups) approaches were employed. They utilised action research methodology involving 214 drug misusers who had been in receipt of methadone for an average of 8.5 years-53% (n=113) were male and 47% (n=101) were female. The initial purpose of the report was to ascertain if methadone Drug Tariff Formula (DTF) was meeting the needs of the people to whom it was prescribed and 88% (n=188) of responders felt that it was not as effective as the previously prescribed Physeptone in staving off withdrawals. Users' views were ignored and UISCE identified high levels of dissatisfaction with methadone and a broader and complex range of problems faced by clients within drug treatment services. Service users described negative attitudes from the professionals working in the drug treatment centres and expressed that they had 'no say' in treatment decisions. They also identified that many of the respondents had been at the receiving end of medical sanctions for what they described as minor infringements of their drug treatment programme. The sampling method, rationale for the sample size chosen and the response rate were not documented, so the generalisability of the study is debatable (Long 2004). The high levels of dissatisfaction with methadone DTF were similar to O'Connor's findings and other issues came to light, which highlighted a much broader and complex range of problems faced by clients within drug treatment services. They described an unequal system of maintenance, which was structured in a way that militated against client involvement and added to the sense of powerlessness. The need to develop a partnership approach where clients could discuss their particular needs with their doctor and a 'tailor-made' treatment programme be devised for them was identified.

Lawless and Cox (2003) carried out an evaluation of a methadone prescribing service in Dublin City during 2001-2002. They employed both quantitative (31 clients with baseline data and follow up of 17 at 18 months representing a 55% follow-up rate) and qualitative research methodologies (focus groups; two with clients and one with service providers). The Opiate Treatment Index covered six main outcomes; drug misuse, HIV risk taking behaviour, social functioning, criminality, health status and psychological adjustment. Of those who remained at follow up, analysis revealed reductions in the quantity and frequency of both licit and illicit drug consumption, less criminality, improvements in social functioning, consistent health but an increase in sexual risk behaviour. The qualitative information highlighted that although the provision of methadone as a treatment option was regarded favourably by the service users the mode of delivery of the treatment was in need of review. Clients reported extreme variations in the prescribing practices of GPs as some were purported to regard treatment as a purely abstinence focused approach with others regarding it as drug substitution. Although the study employed small numbers and was not situated in general practice, a key advantage of GP involvement in the treatment of opiate misusers in the treatment clinic was identified as normalising opiate use by integrating drug treatment with mainstream medical services 'thereby reducing stigma involved'(p117).

O'Reilly *et al* (2005) assessed the views of 25 drug misusers in three focus group discussions concerning their experiences of health services in Dublin. This was a collaborative study of the Participation and Practice of Rights Project (PPR) and UISCE and a general practice. The participants were selected by UISCE. Among various problems identified with the health services and access to them were that 11 of the 25 participants did not have a GP and complained that they were constantly refused registration by GPs. This was a small study and

strong inferences may not be made. The sampling methodology and inclusion criteria were unclear as a combination of methods were used including asking for volunteers, meeting drug misusers in the street and going into the flat complexes searching for volunteers. Consensus opinion from focus groups may not always be the view of the individual. Many of those interviewed were not on MMT in general practice. Nevertheless negative attitudes and reluctance to take drug misusers on to their practice lists was noted as is evident in other international studies (McKeown *et al* 2003).

A further small study was conducted in a north inner city general practice in Dublin (O'Reilly & O'Connell 2006). Forty one of forty seven clients attending were interviewed with a questionnaire that had both closed and open questions. Results showed that 44% (n=18) of clients reported having an agreed plan with their doctor regarding 'where their treatment was going', 61% (n=25) stated that their doctor decided the amount of methadone they were prescribed, with 34% (n=26) stating that they could influence the dose which was decided by doctor and client together. Just fewer than 50% (n=24) felt that they had a say in deciding the prescribed dose with 44% (n=11) wanting to be more involved in decisions regarding their treatment. A separate system of care was identified suggesting that methadone service users were not treated as 'regular clients' but consulted with at an alternative time than other patients. The authors concluded that the MTP of the ICGP encouraged retention and long term maintenance and conflicts with users desire to be 'off' methadone. Services were urged to take account of this and tailor packages with service users to allow them experience progression in treatment as well as shared responsibility for decisions and trust. A 'one size fits all' approach was described which did not adequately take account of service users' goals. This study reflected the views of drug misusers situated in one GP surgery only and these

were treated at a separate time to other patients which is not a universal practise in Dublin. This situation enforces a segregation which supports the concept of marginalisation and could prevent the holistic approach of partnership in general practice services. It is arguable from the findings of this study that the goal of “normalising” drug treatment was unachievable as a separate system of care was operating i.e. situating a treatment clinic service in the same premises as a GP surgery. The study, though not generalisable, offered for the first time a view of how service users viewed their care in a general practice setting.

The guidelines of the ICGP do encourage reduction strategies, maintenance and scope for detoxification and it is debatable from these findings whether these guidelines are being implemented. Guidelines are however produced to provide a framework which does not substitute for clinical judgment (ICGP 2008). Deviation from recommended guidelines is common as some GPs face difficulties in managing multiple drug dependencies which may reflect the nature of the presenting drug problems (Matheson & Pitcairn 2003). James *et al* (2009) conducted a study to explore the health concerns of 261 clients attending a MMT programme in an addiction treatment service in Dublin. Clients identified a high level of health-related concerns, such as psychosocial health concerns, particularly mood-related and concerns about HCV, diet, and sexual and mental health. A further study investigated the health concerns of clients attending a community addiction service in Dublin. Four main areas of concern were identified as smoking, depression, poly-drug misuse and HCV (Connor *et al* 2007). There was no information on how many questionnaires were distributed or the response rate although females accounted for 38.3% of the sample. Although reliability of these Irish studies may be called

into question due to both sampling and reporting inaccuracies, they reflect all that is available in the literature at the current time.

The recommendation in the National Drugs Strategy (NDS) 2001-2008 (DOTSR 2001) suggests that drug misusers' views should be taken into account at all stages of their treatment, however the reality appears to be different. The reality is that there is a lack of evidence to support the practice of user involvement in their treatment decisions in the RoI.

There are no national service standards and guidelines and no mechanism for recording when or how treatment ends, which is a critical indicator of treatment quality and effectiveness (Buckley 2009). There are also no drug service user charters such as those which have been developed in other countries such as Australia (O'Brien 2004). The drug misuser cannot be fully liberated from the power relations inherent in both policy formation and treatment planning as the structural inequality between service providers and service users has not yet been formally acknowledged. Quality of care has not been rigorously assessed in general practice in relation to patients on MMT from their perspective therefore no baseline data from which to examine these and other pertinent issues exist. Audit is carried out by the ICGP but as found in one Scottish study, the model of audit undertaken is important. The lack of a 'universally acceptable yardstick, against which quality of care can be measured' represented concern in this study (Scott *et al* 1999:1793). Instances of substandard care and shortcomings in clinical care were uncovered by this enquiry and this process provided useful opportunities to improve the future management of patients who were being prescribed methadone.

The Report on the Working Group on Drugs Rehabilitation (DOCRG 2007) recognizes that families of service users who have a direct role in the recovery process should be seen as service users in their own right,

however these recommendations have yet to be incorporated into the proposed NDS 2009-2016 and no service user has been invited to join the strategy task force. In an overview of the previous NDS (2001-2008) the assertion is made that it is 'through open, informed and critical debate, involving all players and drawing on all possible sources of information and all perspectives, that the insights gained from strategic implementation, and practical and acceptable options for resolving critical strategic tensions, are found' (Pike 2008:104). Neale (1998) suggests that methadone is a controversial but useful substitute drug, the prescribing of which requires careful and continuous monitoring. To this end, evaluations of methadone should consider the views of those receiving as well as those providing services.

There has been a serious lack of debate in relation to service users' views in the RoI and thus a need to involve these players. The legislation for methadone maintenance was intended to normalise drug treatment in primary care (ICGP 2002, 2003, DOHC 2005) yet the success of this intention has not been evaluated from the perspective of those who are using the service. The values held by treatment providers may not be shared by service users or indeed may be valued differently. There may be a discourse between the bio-medical model and patient views as insufficient knowledge exists about the complexity of methadone treatment and the inter-relationships of the various factors contributing to success or failure of treatment in general practice in the RoI.

Information gathering is essential for effective clinical management of patients with chronic disease (Billings & Stoeckle 1999) and identifying what patient choices are among the options for treatment of heroin addiction necessitates exploration. How service user's views are harnessed requires investigation as it has been acknowledged that they

have the potential to provide support for methadone prescribing regimes (Stone & Fletcher 2003) and their experience of treatment can be influenced by how care is delivered (Neale, 1998 a & b, 1999 a & b, McIntosh & McKeganey 2000, 2001, Fraser & Valentine 2008). The lack of emphasis and debate in the Irish literature surrounding service users' perceptions of their current treatment underlined the urgency of the planned research and also emphasized the gaps that exist.

1.8. RESEARCH AIMS

This study was undertaken against a background of little qualitative work on the lived experience of those attending general practice in the RoI and none that explored the methadone service users' perspective of their treatment solely within this environment (Stern 1980, Field & Morse 1994). The dearth of empirical data highlighted the importance of studying the experience of methadone treatment in general practice. It was uncertain whether discrepancies existed between the reality of the situation for the drug misuser and what the MTP advocates in general practice. Alternative perceptions had not been addressed and the significance of exploring the insight and understanding of service users' experiences had been markedly absent and indeed overlooked in previous studies. It was unknown whether partnership in treatment existed between treatment provider and service user. 'Actual care versus ideal practice', one of the recommended avenues for research advocated by the ICGP research strategy (2003-2008) needed to be investigated and highlighted.

Using the intervention of the MTP this study focused on the meanings, perceptions, and processes that occur within the context of treatment and 'offers a way to explore and understand service users' needs and thereby plan responses' (EMCDDA 2009:18).

The aim therefore was to explore how the MTP was being implemented in general practice from the perspective of the service user.

Objective 1: To describe service users' lived experience of the MTP.

Objective 2: To describe service users' experience of being involved in decision making and management of their treatment.

Objective 3: To discern whether there are shortcomings and benefits of experiencing methadone treatment in General Practice in Dublin.

Objective 4: To identify what steps may be required to address any limitations or deficiencies in treatment by considering the perspective of the service users in the context of current practice.

CHAPTER 2: METHODOLOGY

2. INTRODUCTION

The research design was developed in response to the study aims. In determining what strategy was necessary for the study a thorough review of possible methods was undertaken. This implies a linear structuring to the thesis which is not entirely representative of the emergent design which was not fully formed at an early stage. The debate between which design method to employ in any study, either quantitative or qualitative, can be argued and many feel that polarization is no longer a particularly useful basis for rationalizing a specific approach. Alvesson and Skoldberg (2005) assert that it is not methods but ontology and epistemology which are the determinants of good social science. They identify that these aspects are often handled better in qualitative research and recognize the common view that the choice between qualitative and quantitative paradigms cannot be made in abstract, but must be related to the particular research problem and research objective. A distinction which they discuss as more interesting than that between the paradigms is one that distinguishes between reflective research and research in which the knowledge subject can avoid all critical examination since it 'has been established as methodological reason' (Kittang 1977.33). This discussion influenced the researcher to merge two methodological approaches within the design of the study set within a qualitative model. These approaches were Phenomenology and a specific Reflexive methodology.

2.1. RESEARCH DESIGN AND RATIONALE FOR USING A QUALITATIVE APPROACH

The underlying nature of the investigation was that the emergent process demanded an in-depth understanding of the lived experience of the service user on methadone. The goal of qualitative research is that theory or hypotheses are not established 'a priori' and imposing such hypotheses on the experience of service users would not have been consistent with the research question posed. Phenomenology can be identified as one style of qualitative inquiry but one which involves a particular conceptual and methodological foundation (Seamon 2002). It is a useful methodological approach when the focus of inquiry is narrow (experiences of methadone treatment in general practice), the respondents represent a clearly defined and homogenous bounded unit, within an already known context (urban general practice within Dublin) (Crabtree & Miller 1999). The heart of the phenomenological method indicates a way of study whereby the researcher seeks to be open to the phenomenon and to allow it to show itself in its fullness and complexity through the researcher's own direct involvement and understanding. This style of study arises through first hand, grounded contact with the phenomenon as it is experienced by the researcher (Seamon 2002). The researcher has been involved in managing patients on a MTP for fourteen years as a practice nurse, clinical nurse specialist and for the past four years as an advanced nurse practitioner. Guided by a Husserlian phenomenological research epistemology, it was considered possible to emphasize and describe service users' experience of treatment. The choice to use a Husserlian approach was based on the focus of the study which was descriptive rather than interpretive (Bolton 1987). Interpretive phenomenology such as Heideggerian studies take the process further by analyzing what the participants' descriptions of their lived experience really means.

Descriptive studies are sometimes the only practical way of studying some topics in drugs research and are helpful as they are thought provoking and can suggest further questions that can be investigated using a different approach (Preston 1996). Cresswell (2003) recommends that a choice is required when developing a description of an individual or setting. To study individuals he suggests narrative or phenomenology as useful strategies whereas exploring processes, activities and events are served well by both case study and grounded theory and broad culture-sharing behaviour of individuals and groups are described best by using an ethnographic approach. Thus Husserlian Phenomenology was chosen to be the overarching qualitative method and philosophy which informed the design of this research project. This methodology was considered and used appropriately in the pilot study (3.1). When the methodology was reassessed after this preparatory process was carried out it was recognized that this qualitative method provided a fitting way to continue to investigate the situation.

2.2. PHENOMENOLOGY

Phenomenology has been described as a philosophy, an approach and a method that possesses a reverence for experience (Olier 1981). It is a research philosophy that finds its roots originally in Kant's seminal work – *Critique of Pure Reason* (1724-1804) (cited in Cooper 1999). Kant proposed that any objects we can experience must conform to what we contribute to experience through our cognitive powers. Husserl, the Moravian born philosopher (1859-1938) added his view to Kant's theory of knowledge and published *The idea of Phenomenology* in 1907. He described the aim of phenomenology as providing fundamental descriptions, free from distortion by theoretical presuppositions and prejudices (Cooper 1999). The notion of "phenomenological reduction"

was described, which is a central tenet of this approach. The phenomenologist's first task, if he is to expose and describe, is not to doubt, but rather simply to "bracket" or abstain from his or her natural beliefs. This bracketing is a radical approach to research as it involves ignoring an assumed relationship to a material world. This bracketing or abstention is referred to as "epoche" (from the Greek word cessation) and it is the first stage of the research process in Husserlian phenomenology. Abstention is necessary in order to focus solely on the mental acts of cognition (focusing on the things themselves). This means that the subject of interest is approached without any preconceived expectations or categories and therefore the method is not restricted by the impositions of such structures (Omery 1983).

Epoche or phenomenological reduction involves two stages. The first stage, eidetic reduction, is reduction from particular facts to general essences, that is, suspending what one already knows about the phenomenon under investigation. The second stage, the transcendental or phenomenological reduction, frees phenomena to come directly into view, rather than be viewed through the preconceptions of the researcher, because temporarily, the natural attitude is suspended (Morse 1994).

Husserl explained that everything that is transcendent must be assigned to the "index of indifference" an index which indicates that it is not the researchers concern to make judgments (Cooper 1999). This enables the researcher to "intuit" or see the essence of knowledge or the phenomenon under investigation. When the looking and noticing and looking again are complete a more definitely reflective process occurs, aiming at grasping the full nature of the phenomenon.

The final step in the phenomenological research process is the intuitive integration of the textural and structural descriptions into a unified whole. This is the synthesis of the process that presents the meaning of the phenomenon under study. Moustakas (1994:101) concludes that

through epoche, phenomenological reduction, imaginative variation and synthesis, one learns to 'see naively and freshly again, to value conscious experience, to respect the evidence of one's sense and to move towards an inter-subjective knowing of things, people and everyday experience'. The focus of the study was to understand the phenomenon from the perspective of the study's participants. In other words, the phenomenologist pays attention to specific instances of the phenomenon with the hope that these instances, in time, will point toward more general qualities and characteristics that accurately describe the essential nature of the phenomenon as it has presence and meaning in the concrete lives and experiences of human beings (Seamon 2002).

2.2.1. METHODOLOGICAL CHALLENGES OF PHENOMENOLOGY

Husserl's pursuit of the idealist philosophy prompted him to advocate 'ideal bracketing'. This is based on the researcher's epistemological position and theoretical framework of descriptive phenomenology and is a philosophical model which was used as a standard point from which to contrast and develop ideas (Gearing 2004).

It was acknowledged from the outset of this study that any ambition on the part of the researcher to claim authority in determining "how things are" or "how best to interpret a phenomenon" would be problematic as the researcher is involved in the clinical setting of methadone maintenance as a practitioner and is influenced by professionalism in that specific area. One description of a professional has been expressed as an individual who exhibits a high degree of independent judgment, based on a collective, learned body of ideas, perspectives, information, norms and habits and who engages in professional knowing (Baskett & Marsick 1992). If this is an accepted definition the question of how professionals can listen to, and learn from their clients

is problematic unless they step outside these learned behaviours. The research setting resembled the clinical setting where power and influence may have been associated with the procurement of a methadone prescription. There was a potential for inherent bias that could arise from the researcher's personal practice knowledge and professional background. Acquired consulting skills associated with managing patients receiving methadone may have influenced the researcher to make assumptions about interpretation ahead of data analysis and so influence its construction. It was necessary to confront these concerns at the outset and to widen the focus of methodological thinking in research paradigms in order to cope with the complexity of these issues.

Reflection and reflexivity in the guise of "bracketing" was an essential part of the method of inquiry but the process of bracketing appeared ill defined and a specific methodological technique of how the reader could assess the degree of researcher influence presented a challenge to validity. Gearing (2004) suggests that 'the growing disconnection of the practice of bracketing in research from its origins in phenomenology has resulted in its frequent reduction to a formless technique, value stance, or black-box term'. Existential bracketing adopts only the first component of bracketing, that is, the setting aside of suppositions (Moustakas, 1994). This can present methodological challenges for the researcher as there is no one shared form of bracketing which has an accepted understanding nor can researchers assume that others universally share their conceptualization or operationalisation of bracketing (Gearing 2004). A specific explicit methodology was therefore required to reduce ambiguity and imprecision.

To address these limitations and to produce a study within which data were collected and analyzed 'in ways that did not prejudice their subject matter' (Ahern 1999) a creative layering of reflexive methodology was utilized in the form of bracketing interviews. This was a means of both

widening the perspective in the work and making reflection an integral part of the study. Thus the two distinctive approaches of Husserlian descriptive phenomenology and reflexive methodology were combined and blended throughout the study. This reflexive ambition acknowledged that the researcher was left “open” to interpretation and criticism which represented a novel version of reflexivity for the purpose of the study.

2.3. REFLEXIVE METHODOLOGY

Reflexivity is an approach which is based on the assumptions-and implies-that no element is totalized; that is, they are all taken with a degree of seriousness, but there is no suggestion that any one of them is the bearer of the ‘right’ or ‘most important insight’ (Alvesson & Skoldberg 2005:249). Methodological concepts such as bracketing have evolved beyond phenomenological philosophy and although reflexive bracketing has its origins in phenomenology it is also recognized in other qualitative research. Simply acknowledging that bracketing was used without describing the bracketing process employed in the research can critically undermine the scientific value of an investigation and subsequent findings (Gearing 2004). Sensitive research such as exploration of drug misusers’ experiences presents methodological, ethical, and emotional challenges.

Rolls & Relf (2006) interviewed bereaved children and their families and identified ‘bracketing interviews’ as a method of managing both the researcher’s methodological tension between subjectivity and objectivity, and the problems that can arise when undertaking emotionally and ethically challenging research. Reflexive bracketing makes transparent the researcher’s personal values, background, and cultural suppositions by exposing them to the reader who interprets. In this way a more open-minded creative interaction between theoretical

frameworks was demonstrated. Both of these approaches were dependant on the experiences of both the researcher and the researched.

Reflexive interpretation is described as the opposite to empiricism and theoreticism (the use of a single abstract framework offering a privileged understanding) and what also has been described as “reflective reductionism”. The idea is to “allow room” for elements other than the problematisation of text authority relations and to avoid the latter dominating (Alvesson & Skoldberg 2005:249). The technique of the bracketing interviews fulfilled this important aspect of reflexivity as these interviews were observed at regular intervals throughout the main study. In reflexive work it is important to divide a research project into different phases with respect to the reflective elements and sequence interpretations (Alvesson & Skoldberg 2005). Including definitive phases during which the researcher interpreted her empirical work in reflective terms it was possible to generate more interesting interpretations into the results.

The contribution of bracketing interviews was considered not only as a means of “laying bare” assumptions of the researcher but the methodology was expanded to include the voice of the researcher and bracketing interviewer alongside the voice of the participants. Polyvocality and reflexivity are useful strategies employed in qualitative inquiry and show evidence of the emergence of the design, the shifting nature of the methodology, continuous review of the literature and progressive subjectivity of the researcher (Denzin & Lincoln 2000).

It is recognized however throughout the study that there is no naïve assumption that the totality of any experience can be captured. The reality is that no matter how extensive the recollection and recording of data related to that experience has been the process has been selective (Piantanida & Garman 2009).

2.4. ETHICAL CONSIDERATIONS

The evaluation of potential risks inherent in any research is required before the study begins. Ethical approval was obtained from both the ICGP Research Ethics Committee and also the School for Health University of Bath, Research Ethics Panel. Informed consent, willingness to participate in the study and assurance that the participants could withdraw from the study was a prerequisite of the inquiry (Appendix 3). The best judges of whether an investigation will cause harm or cause offence may be the members of the population from which the participants in the research are drawn (British Psychological Association 1985). It was acknowledged that the research relationship with vulnerable groups is inherently an unequal one and the use of key informants at the pilot stage was utilised partly as a method of participatory action.

Research participation and findings can be influenced by a therapeutic relationship with the respondent. Acknowledging this the researcher was precluded from interviewing her own clients at the Liberties Primary Care Centre. An assistant researcher skilled in qualitative interviewing was employed for this purpose. This researcher was employed as a post-doctoral fellow in the Department of Anthropology in the National University of Ireland Maynooth. She was skilled in the use of various research methodologies and worked in conjunction with the principle researcher. Her technique at interview was to get a general picture in which the specific topic of interest could be situated and then further explored. It was explained to the participants that the assistant researcher was not an independent interviewer but that the responsibility for the outcome of the research lay with the principal investigator. Other particular ethical issues which had to be considered were those which addressed the potential of coercion for participants,

both those in the researcher's own practice and those in the GP practices which were involved in the study. Drug misusers are not listed in the category of 'especially vulnerable' populations (Gorelick, Pickens, & Bonkovsky, 1998) but drug misusers do provide unique challenges. Co-morbid conditions that could affect their ability to comprehend the requirements of the research, including co-morbid psychopathology, cognitive impairment secondary to substance use, or limited educational attainment are all possible difficulties. Many drug misusers have legal involvement and charges "pending" therefore freedom to make a choice to participate in the research may have been limited by these circumstances. The collection of personal sensitive information regarding illicit drug misuse presents issues in relation to consent, privacy and the balance of risks and harms (Fry & Hall 2005). The notion of calling the participant a "key informant" for example concerned one interviewee in particular as he felt this identified him as a "rat" or police informant. Ning (2005:356) also noted that she was cautioned to avoid this standard anthropological term in her ethnographic study of a methadone clinic in Toronto as it may have been seen as betraying 'the secret code of solidarity between drug misusers'.

It was also important to acknowledge that freedom to make a choice to participate in the research may have been limited by the service users' understanding of the research intent and they may have found the prospect of a study reflecting their views as potentially intimidating. Research which was carried out at the clinical site where methadone was prescribed had the potential for influencing the participants negatively. Their responses may have been influenced by the fact that their GP had asked them to participate and they may have wished to comply with his /her wishes as they may have considered that refusal could have jeopardized their treatment. Equally this may have been a deterrent for some to become involved. It was acknowledged that the very fact that participants would be talking about their own experiences

and raising awareness of the role methadone has in their lives could potentially upset patients and/or change the way they view or manage their situation. Re-reading the transcripts of their stories shown to them for the purpose of validity, the participants would be required to refocus on their interpretations of their experiences which heretofore may not have occurred to them. While this ensured that participants had the opportunity to voice their responses to the study, it was documented in the patient participation leaflet that difficult issues pertaining to any aspect of the study could be followed up by telephone with the principle researcher (Appendix 4).

There was also acknowledgement of procedures to deal with situations when confidentiality may have potentially needed to be broken, for example if the participant revealed evidence of suicidal ideation or child misuse or neglect. Participants were informed of this policy prior to interview and it was stated that the researcher would be obliged to inform their GP if any of these issues arose. Access to care was inherently provided as participants were in receipt of ongoing continuous interaction with their GP. If during the course of interviewing it was identified that the participant was in need of further support or care which was beyond the scope of the researcher's brief there was assurance that the participant could be referred back to the care of their GP. This was necessary in one instance when the participant disclosed previously undisclosed issues of rape to the interviewer. The participant was encouraged during the course of the interview to discuss these issues with the GP. This was carried out and it was acknowledged during the course of the interview that the consent form had documented this possibility. Participants were informed of all procedures that ensured confidentiality. As a member of the practice team identified potential participants, it was acknowledged that the practice team then remained uninformed of the interview material and had no access to interview transcripts. Audio tapes were kept in a

secure place, accessed only by the researcher and the transcriber who was bound by a signed confidentiality agreement. This was the same transcriber who had transcribed the previous study (*The perceptions and experiences of practice nurses in relation to patients on a MTP*), is employed in health services transcription and was knowledgeable in understanding local slang terms. Tapes and transcripts of the interviews will be destroyed after a period of five years. Access to research data was limited to the lead researcher, transcriber, supervisory team and technical support only.

Ethically research should be designed, reviewed and undertaken to ensure integrity and quality. As research should also be conducted in order to ensure the professional integrity of its design (REF 2005) a pilot study was carried out to confirm feasibility.

CHAPTER 3: METHODS

3. INTRODUCTION

This chapter outlines and critiques the methods used to conduct the work which was divided into stages, Phase 1 and Phase 2. The specific objective of Phase 1 was to conduct a pilot study to train the researcher in as many elements of the research process as possible and at the same time identify any potential problems with the design of the main proposed study. The rationale was to draw attention to specific practical problems in following the research procedure so that early shortcomings in the process could be identified, thus endeavouring to ensure feasibility in the main study. Valuable lessons were learned which informed and benefited the work.

3.1. PHASE 1-THE EFFECT OF THE PILOT PHASE ON THE EVOLVING DESIGN

The pilot phase of the study (Phase 1) was conducted between November 2007 and April 2008 as part of the Doctorate in Health programme-Unit 7. It provided structure and direction to the project and addressed the multiple levels of reflection required before the main study began. It served several other pragmatic functions not least to raise the researcher's awareness of the various interpretive levels that would be required throughout the study. Methodological, conceptual and pragmatic lessons were learned from a preliminary investigation of three service users receiving methadone in two general practice sites. Both the researcher's practice and another practice were used exclusively for the pilot phase. During the pilot phase, these three service users who could articulate and engage with the process of interviewing were interviewed. The researchers (both principal and assistant researcher) had prior knowledge of these participants. These

were considered to be key informants as these relationships had been cultivated over time by both researchers. Previous involvement with service users' groups was considered to be advantageous as these participants would have had knowledge of the local community and would have been aware of how the MTP had historically and culturally impacted on service users. Two were actively involved in service users' groups and education within their respective communities. This "cultivation of relationship" was a crucial consideration for the main study. This method served as a way of informing the researcher about the community, prior to embarking on the main study. This proved to be effective as the principal researcher was assisted in comprehending various aspects of the environment which were previously hidden from her lens as a practitioner. The methodological approach of phenomenology was tested and was proved apposite for the study. Three main outcomes from the process of piloting were identification of a sampling methodology, preparation of the site and preparation of a topic guide.

3.1.1. LESSONS LEARNED: SAMPLING FRAME

Factors known as 'sensitizing concepts', (Patton 1991:391) such as length of time a patient is in treatment, were initially considered to be important to include in the sampling frame. It was considered that identifying participants who were receiving treatment for longer than one year would more adequately reflect continuity of care in general practice. One of the informants however did not fulfil the initial criteria and in the light of the wealth of data that was elicited from this interviewee, it was decided to review the inclusion criteria for the main study. The decision was taken to include all service users registered with their GP for MMT without defining a rigid time frame of treatment. Wilmot (2005) warns that in sampling strategies the full range of

dimensions and information needed to inform the sample selection should be covered. The effect of under-coverage could have misrepresented the results. This information concerning the clear definition of the sampling frame informed and proved valuable for the main study. The logic and power of purposeful sampling in selecting information rich cases are identified in Patton's typology (1990) and this sampling strategy was consistent with the methodological approach of phenomenology. Thus the sampling methodology was purposive within a maximum variation sampling strategy.

An alternative approach to sampling, such as snowball sampling was considered. Snowball sampling implies that the researcher makes contact with a small group and then uses this group to establish contact with others (Bryman 2004). Snowball sampling is often used in drug services' research, however due to the nature of this inquiry it was important to provide a discrete and confidential environment where other drug misusers could not influence the interview, as individual views rather than cohort views were sought. If snowball sampling had been utilised, maximal variation strategies would have been compromised. If snowball strategies had been considered appropriate, the use of incentive payments to encourage recruitment would have been considered. This may have biased a response rate which included those not naturally predisposed to volunteering and service users may have had to be rejected on the basis of not being able to articulate their experiences. This may well have caused bias. Given the aims and objectives of investigating care in general practice, the sampling strategy provided confirmation that those interviewed were indeed currently in receipt of methadone treatment from a general practitioner rather than a treatment centre and had been selected on the basis of being comfortable articulating their story.

In some respects the service users may have felt privileged to have been chosen as participants. Conversely, it has to be acknowledged

that this sampling methodology excluded service users who have difficulty in communicating and were not identified by GPs as being confident in an interview situation.

Situating the study in the general practice surgery had the benefit of grounding the inquiry within the domains of consulting times as it was important not to interfere with the working day of practitioners. Situating interviews outside the practice may have been dependant on snowball sampling techniques which would not have had the same potential for safeguarding the location for the researcher. The participants were also safeguarded by this approach as ethical issues were disclosed (such as rape, 2.4) and required GP intervention.

3.1.2. PREPARATION OF SITE

Another lesson learned was to prepare and adequately familiarise the GPs with the inclusion and exclusion criteria prior to the selection of potential participants. It was obvious during the pilot phase that the criteria appeared vague and there was insufficient explanation and communication with the GPs prior to interviewing. Obtaining the voluntary participation of GPs in quality of care research is a major problem with research within general practice, as providing medical care to sick patients may not dovetail straightforwardly with acting as research gatekeepers (Borgiel *et al* 1989). GPs may receive comprehensive specifications, but time and workload pressures may make it difficult for all but the most enthusiastic staff to get involved in research (Shakespeare 2006). With this in mind a simple letter outlining the process and a step by step guide was devised to achieve clarity and enable a more streamlined approach to recruiting. This was piloted with three GPs who gave guidance on the framing of the guide. All agreed that the recruitment process appeared straightforward and this guide

was used for the main study, preventing any further uncertainty (Appendix 5).

3.1.3. PREPARATION OF TOPIC GUIDE

Developing and testing the adequacy of the topic guide was a vital feature of the pilot project. An interview topic guide was used to ensure that a number of pertinent issues were addressed. The preparation of the topic guide was important to make sure that relevant topics were covered. It is understood that no interview is completely devoid of structure as, if the corollary were the case, there would be no guarantee that the data gathered would be appropriate to the research question (Mays & Pope 1997). This being the case the interviewers were free to explore, probe and ask questions deemed interesting to the participants. The topic guide was piloted and reshaped and refined following each interview until an understandable dialogue was facilitated for Phase 2 of the work. Both interviewers gained insights from the previous interview which were used to improve interview schedules and specific questions (van Teijlingen & Hundley 2001). Certain aspects of the questioning such as *What is it like to be a methadone patient in general practice?* were changed to; *What is it like to be receiving methadone in general practice?* (Appendix 6). The former line of questioning could have been perceived as labelling and insensitive to the participants and as a core question could have potentially been misunderstood. It was important for the interviewer to remain open in the presence of new and unexpected descriptions of the participants' experience so therefore there was no rigid adherence to a specific line of questioning. The phenomenological interviewer does not shape the questions as tests of ready made categories or schemes of interpretation but is required to keep the focus on non-theoretical descriptions of the experience (Polkinghorne 1989:49).

3.2. PHASE 2

As a result of reflecting on the process of the pilot study the following criteria for selecting participants was utilised for phase 2.

INCLUSION CRITERIA

- a) Those willing to participate and provide informed consent i.e. no coercion or incentives were offered.
- b) Those who attended a doctor qualified to treat at Level 1 i.e. stable patients and those who attend a doctor qualified at Level 2 i.e. less stable patients.

EXCLUSION CRITERIA

- a) Those who refused to be involved
- b) Severe psychiatric co-morbidity as assessed by their own GP.
Colazzi (1978:58) states that experience with the investigated topic and articulateness suffice as criteria for selecting subjects.
- c) Over 20 years of age, as MMT is not encouraged as first line treatment for adolescents and in general they are not in treatment in general practice (ICGP 2008).

3.2.1. RECRUITMENT SPECIFICATION-PHASE 2

Recruiting to primary care studies is complex and the difficulty of recruitment in primary care is under emphasised in the literature (Dyas *et al* 2009). The step by step guide (3.1.2) was utilised for recruitment in Phase 2 which was conducted between August 2008 and January 2009. This recruitment specification detailed both the recruitment strategy for GPs and a letter explained the purpose of the research and

how the research was to be conducted and for whom (Appendix 5). An initial letter was sent to GPs six months prior to the start of the study and subsequently followed up by a combination of email and telephone contact to ensure agreement with the recruitment methods and consent to the project. The rationale for site selection is given in 3.2.2.

As the actual sampling and recruitment took place in the field, the potential respondents who fulfilled the sample criteria and the overall sampling strategy were dependant on the invitation issued by the GP. This meant that recruitment was subject to the 'gatekeeper syndrome' (Wilmot 2005). The GP gatekeepers were the people who had the power and the influence to keep the research project from being investigated. The insight of the GP was paramount to effective recruitment as he or she were the only ones who could attest to the suitability of the participants' abilities to engage with the process. Each GP was asked to identify service users whom they considered had sufficient experience of the topic of the research i.e. methadone treatment. The second requirement was that a service user should have the capacity to provide 'full and sensitive descriptions of the experience under examination' (Polkinghorne 1989:47). This method of participant recruitment was effective but not without difficulties (3.2.3). Gate-keeping as part of a research project is a complex process. In order to facilitate gate-keepers the researcher needs strong interpersonal skills, a sound understanding of ethical principles and knowledge of who can be approached for advice and when to do so (Lee 2005). Other gate keepers approached were at an organizational level such as the research committee of the ICGP who supported the study with a research grant and suggested the support of the national GP drug co-ordinator at a professional level. The use of the GP as gate keeper to target these service users was a deliberate decision to ensure that vulnerable patients were protected and a method of ensuring that the participants would be able to provide rich material. Rich responses to

the research question were produced and enabled an in-depth descriptive account to be generated. Using the GP prescriber as gate keeper undoubtedly may have influenced the accounts of service users however the fact that negative experiences with these GPs were elicited during the in-depth interview, without probing, suggests that this approach was useful. A voucher for 20 euro for a local department store was given after the interview had occurred. Neither the GPs nor the participants were informed of the voucher prior to interview as this knowledge may have also have been used as an incentive to recruit clients on the part of the GP, if this were known. If offered, it would be doubtful if the rich experiences shared by those who genuinely wished to contribute would have been tapped into or if confidentiality could have been maintained within this chosen cohort. Each participant volunteered to participate when approached, without this knowledge, some suggesting that being involved provided a way of "giving something back" to the GP for the care which they had received in treatment. Thus those who responded to invitation by their GP expressed that they genuinely wished to tell their story and give voice to their experiences.

Recruitment had to be monitored regularly with potential barriers such as these and other pragmatic problems encountered such as participants' lack of mobile phone credit. These issues were addressed iteratively as the study progressed (Dyas *et al* 2009). As phenomenological research interacts in a personal manner with those asked to provide examples of their experience, the researcher, assistant researcher and participants were all research instruments utilised for obtaining these descriptions (Polkinghorne 1989:47).

3.2.2. GAINING ACCESS TO RESEARCH SITES

The same general practice sites where access had previously been granted in 2003, in addition to the independent pilot site, were utilized, building on the researcher's previous study exploring *The Perceptions and Experiences of Practice Nurses in Relation to Patients on a Methadone Treatment Protocol* (Latham 2003). A particular strength of the study was that these sites were identified early in the study by means of personal contact and gaining access was planned months before the research took place. GPs were known to the researcher due to the previous study carried out in their surgeries and this proved to be a very valuable inroad for both the preparatory work and the main study.

Willingness to participate was ascertained by the GP prior to engagement in the research study. Participants were approached with the use of a participant information leaflet (Appendix 4) which had been left with the GP. This leaflet was read with the participant to explain how interviews were to be carried out and information about the aims of the study provided. Assurance was given that at any stage of the research process the participant was at liberty to withdraw from the study. The prospective participant was afforded time between understanding and reading consent and before signing and engaging in the study. Although the participant leaflet had been left with the GP prior to the researcher gaining consent, the leaflets were re-read with the participant prior to the interview again. Consent was obtained by the researcher. Informant wishes and constraints were taken into account and the standard patient consent form for participation in non-clinical trials, developed by the Research Ethics Committee of the ICGP, was used in the study (Appendix 3).

It was acknowledged that the setting of an interview affects the content and it is unknown to what extent the site influenced the full exploration

of service users' experiences. However the wealth of data which were provided to the researcher by the participants did explore and illuminate both negative and positive experiences with treatment provision. There is no doubt that locating the interviews in general practice may have inhibited honesty and may have impacted upon the service users' account regarding their experiences of treatment as service users may have felt that their treatment could have been adversely affected by not consenting to the research. On the other hand several of the service users who did give consent to the GP did not respond to repeated phone calls from the researcher to be interviewed which may suggest that they agreed with the GP at the time of consultation but reconsidered once they reflected on the implications of involvement.

3.2.3. OUTCOMES OF SAMPLING

Minimal exclusion criteria and maximum variation sampling favoured an inclusive selection process that provided the possibility of a large sample and it did not seem difficult for the GPs to provide several candidates. Not everyone approached to take part was agreeable, particularly as the length of the interview which was indicated in the participant information leaflet proposed an hour. Although this is speculative, the refusals were possibly not related to the research topic but rather the length of time required for the interview as two service users defaulted at the interview time citing difficulties with managing the length of time required. Deficiencies in the sample were avoided however as there was a sufficient pool of participants in each practice to provide coverage. The refusals may, in part, be as a result of misunderstanding of the recruitment strategy on the part of the GPs. Some endeavoured to recruit those who were rushing to the chemist to get their prescription of methadone and were possibly beginning to withdraw when approached. The influence of methadone as a drug on

the interview process is a variable which may have impacted on the articulation of the experience as illustrated by the words of one of the interviewees *cause you know it suppresses your feelings and that like.*

Three accepted the invitation to be interviewed but did not turn up or left the surgery once their methadone prescription had been picked up, despite assurances to the GP and researcher that they would attend. One of these was a client in the researcher's own practice who despite reminders and assurances did not arrive to be interviewed by the assistant researcher. Nevertheless those that were recruited (n=25) proved attentive to the research aims and provided rich descriptions of their experiences which informed the study.

The sample comprised 25 people, 14 females and 11 male service users from Dublin, all white and of Caucasian race. Age range was from 23-43 years. Nineteen of the participants were parents and the majority had 2 children. Eighteen had achieved either the Irish academic qualifications of Junior or Group certification and 6 had completed their Leaving certificate. Five females and 5 males knew they had HCV with one of the sample unaware as they had chosen not to be tested. Current methadone dose ranged from 20-150 mgs/per day. Those patients in treatment longer were receiving higher doses. Years in treatment ranged from 1-12 years with the majority in treatment longer than 5 years. The 9 practice sites visited for the purpose of the study were well equipped surgeries with secretarial support, IT facilities and all had the services of at least one if not two practice nurses. There were 13 practice nurses, 42 GPs and 487 methadone patients registered with these 9 practices. The combined patient lists were approximated at 270,000 patients (Appendix 6 Figure 5).

3.2.4. DESCRIPTION OF SITES

The site for each interview was context bound within urban general practice surgeries in Dublin city. The researcher utilized a consulting room in each designated surgery which was provided at no cost by the GPs. Situating the interviews in these settings served several pragmatic functions:

- a) It provided a venue to conduct the interviews in an area which was free from distractions and quiet.
- b) It was a well known and locally accessible site which was routinely accessed by the interviewees.
- c) It was considered a safe place for interviewing and identifying the clients as the interviewer had no known reference point prior to the interview.

3.3. DATA COLLECTION

The method of phenomenology involves drawing on three sources to generate descriptions of experiences:

- a) The researcher's personal self reflections on the incidents of the topic that they have experienced. These were extracted from the bracketing interviews and field notes.
- b) The participants in the study who describe the experience under investigation in response to the interview. These were drawn from in-depth interview transcripts, text messages and telephone conversations.
- c) Depictions of the experience from outside the context itself—i.e. previous investigations (Polkinghorne 1989). These were extracted from

the masters' study *The perceptions and experiences of practice nurses in relation to patients on a MTP* (Latham 2003) and current experience presented by one of the participants who reflected on the aims of the study and presented his feelings and experiences in poems.

These three main data sources were utilized when gathering data.

Other data were collected such as descriptive statistics, memos and charts which were created by the researcher (Appendix 7).

3.4. THE RESEARCHER'S SELF REFLECTIONS

During the process of data collection it was acknowledged that reflection did not conform to any linear process as the researcher became more immersed in the data and creative thought developed (Appendix 7). The use of self reflection was utilized as a way of approaching the topic afresh without prejudicing the study. Awareness of presuppositions and biases provided some protection against the imposition of the researcher's expectations on the study however this approach was further strengthened by the ongoing reflection which was documented during the bracketing interviews. Five bracketing interviews were carried out. These interviews lasted between thirty minutes to one hour (3.5.1).

3.4.1. THE PHENOMENOLOGICAL INTERVIEW

The second source of data was from the participants themselves. The phenomenological method is described as 'a process of learning and constructing the meaning of the human experience through intensive dialogue with persons who are living the experience' (Liehr & Marcus 2002:144). This dialogue was facilitated by in-depth interviews which were used to explore the evaluation of the "lived in and through" experience of receiving methadone treatment in general practice. Data

gathered and generated from the original sources of those who had and were experiencing methadone treatment in general practice were the central focus of the information.

Phenomenological researchers need reports of the experience under investigation 'as it actually appears in a person's consciousness' (Polkinghorne 1989:46). Characteristically, interviews were open-ended requiring enough time to explore the topic in-depth. Interviews lasted anything from 45 minutes to an hour and a half. This format allowed the researcher to follow the informant's lead asking for explanations and examples of their accounts which were meaningful and culturally salient to the participant and rich and explanatory in nature. The topic guide revised as a result of the pilot was used to ensure that a number of pertinent issues were addressed (Appendix 6). This type of interview approach was useful for eliciting information about specific topics. As qualitative data collection and analysis is often progressive, the subsequent interviews proved more informative as this process of gaining insight from the previous interviews was used to improve the topic guide further. Data were collected by the use of two audio tape recorders. This permitted both transcription by the transcriber and simultaneous listening by the researcher. Continuous refinement was beneficial to gaining understanding of the phenomenon (van Teijlingen & Hundley 2001). The descriptions proffered required the researcher to tease out the details and context that constituted the experience and it was often in the latter stage of the interview that descriptions became clearer and richer. The in-depth interview technique proved an appropriate method of facilitating this process.

In a consultation, the differences are overt between doctor and patient as the consultation is usually patient initiated and problem orientated unlike the research interview which is researcher initiated (Hoddinott & Pill 1997). Minimizing social differences such as status, educational level, expertise and appearance can be difficult as found in other

studies in general practice (Hoddinott & Pill 1997). The researcher attempted to minimize these differences by dressing in casual clothes. Although a familiar environment was used where there was a definitive power imbalance between prescriber and service user, this was somewhat addressed by the researcher sitting in the patient's chair and the service user sitting in the doctor's chair. Given the complexity of the issues of engaging a hard to reach population every effort was made to redress this imbalance by ensuring a relaxed interviewing style and treating service users as experts in their own care. This in some way served to shift the power balance from one of service user to expert reporter.

The aim of phenomenological enquiry is to 'reveal and unravel the structures, logic and inter relationships' that are obtained in the phenomenon under inspection (Polkinghorne 1998:50). This is a lengthy process which required that an accurate essential description be gleaned from a myriad of lengthy dialogue and reflected a coherent understanding of the experience of methadone maintenance in general practice.

3.4.2. PREVIOUS INVESTIGATIONS

The third source was the use of data from the previous explorative study which originally focused on the perceptions and experiences of practice nurses in relation to methadone treatment. Experiences which practice nurses expressed from their own perceptions of how they managed patients on a treatment protocol informed this study. Issues directly related to the current study were extrapolated from the text of the previous explorative study (Latham 2003) in order to illuminate further the experiences reflected in the current study and build on the knowledge gained from the previous investigation.

3.5. ROLE OF THE BRACKETER

In phenomenological psychological research, self reflection is typically used as a preparatory step to gathering data. It is acknowledged that the researcher has been influenced by diverse approaches to the treatment of drug addiction (Appendix 8 Reflection). A reflexive approach is one in which reflection on the research and the influence of the researcher is emphasized throughout the study. This process acknowledged the context and subjectivity of the researcher and how this affected both the data gathering process and the analysis of that data (Hale *et al* 2007). Although these influencing factors were identified and were subsequently “bracketed”, value judgements made during the process were noted and explicated as the project progressed. Rolls and Relf (2006) state that bracketing interviews require an experienced bracketer who understands the nature of a supervisory relationship with the researcher that differs from both academic and personal supervision, and who also has an understanding of the demands of research. With this in mind the expertise of the chartered counselling psychologist attached to the researcher’s GP practice was drawn upon to fulfil the function of facilitating this approach.

Her considerable experience working with addicted clients and her own academic experience as tutor, practitioner and supervisor was essential to this role.

3.5.1. FIRST BRACKETING INTERVIEW

Bracketing initially presented a particular challenge in the pilot study to the researcher as a tension existed between the dialectic process of investigating the nature of the participants’ experience and at the same time holding onto the clinical experience of being a practitioner (Rolls &

Relf 2006). It was important to consider that the interaction with the data that occurred for the practitioner/researcher could have influenced how that data was constructed. Crotty (1998) asserts that assumptions can shape the meaning of research questions, the purposiveness of research methodologies and the interpretability of research findings. The first bracketing interview began the process of laying bare the researcher's position as a practitioner while consistently admitting the ambiguity of the position of researcher/practitioner role. Excerpts from the bracketing interview were subsequently interspersed with the data. The voices of the psychologist and that of the principle researcher were used as a method of contributing to the multiple perspectives and voices which were part of the reflective process. The convention of intertwining quotations with the researcher's interpretations and describing the narrative outcome in relation to the general literature on methadone treatment is a strategy identified by Cresswell (2003). The methodological approach of presenting the data in this way meant that each interpretation was approached 'afresh' without preconceived notions about what might be uncovered during the investigation (Polkinghorne 1989).

Bracketing Interview 1

Psychologist (P) How do you get yourself into those clients' shoes?

Researcher (R) It's very difficult if you've never experienced it, you can not understand ...if you've never taken heroin, if you've never taken methadone.

This excerpt describes the initial conflict the researcher had in "suspending the natural attitude" and understanding the phenomenon of the substance of methadone as treatment. Methodologically, this was also a challenge as the phenomenologist's first task is simply to 'bracket' or abstain from his or her natural beliefs ('epoche') (Omery 1983). This initial interview set out the importance of bracketing the researchers' experiences and the potential for impact on data collection.

It was identified early in the study that there was 'no one way street between the researcher and the object of study; rather, the two affected each other mutually and continually in the course of the research process' (Alvesson & Skoldberg 2005:29).

3.5.2. SECOND BRACKETING INTERVIEW

The second interview took place when a third of the data had been collected. This interview helped access the unconscious assumptions and values that may have impacted on the conduct of the research (Rolls & Relf 2006). Identifying that boundaries were being maintained between the researcher/practitioner roles, it was apparent that the researcher was more content and confident moving into the role of researcher and setting aside the natural instinct of clinician. The following excerpt describes the researcher's response to being approached by a receptionist to test the urine of a research participant and how this was managed.

Bracketing Interview 2

P. And obviously you've got to put that to one side and be impartial in the research don't you?

R Absolutely, the receptionist asked me would I like to test the girls urine, and the girl herself said to me- "I thought you were testing the urine cause I heard you were a nurse?" and I said, "well, I'm not a nurse today, I'm a researcher and I have no right to test your urine.... and I certainly am not getting involved in this aspect of your care".

P So you are keeping those boundaries?

R Yep, I kept those boundaries very quickly and there wasn't a problem there... I went in as a researcher I didn't go in as a nurse... I went in (to the treatment environment),... and I felt it was a... more informed view of what it is to ask questions outside the clinical mode.

3.5.3. THIRD BRACKETING INTERVIEW

The third bracketing interview was carried out when almost all of the data had been collated. A further three interviews were scheduled in two surgeries and it was necessary to reflect on the personal responses within the context of the data obtained and how to interpret that data as professional background is an important influence on data interpretation (Barbour & Featherstone 2000). This interview explored how the researcher was feeling about listening to the service users' experiences within the confines of the interview. There is no ability to control the time frame of the interview to a ten minute discussion as is usual within the confines of a consultation. Therefore more details of the nature of the lived experience are expressed.

Bracketing Interview 3

P Ok and the stuff I was looking at last month vicarious trauma any of that?

R Yeah, I think, eh yeah, certainly some of the stories I've heard I have gone home and thought my goodness these are horrific stories! I know that when I see patients normally I'm used to their life story but I don't spend an hour talking to them, I spend a very short length of time with them, this is time... I'm really being allowed into their lives and experiences... and it is painful for them and me.

3.5.4. FOURTH BRACKETING INTERVIEW

The third and fourth interview focused on the interface between the researcher as a person and the research data that was explored. It also addressed the responsibility of the researcher in presenting the data. This interview explores the determination of the researcher in exposing the elements of poor prescribing practices that have been recounted.

Bracketing Interview 4

R well talk about danger! the issue is that you know when I report these experiences they're not going to be well received in many quarters, they will be received well with those who are really passionate about looking after people properly.

P and how are you going to, how are you going to legislate for that?

R I can't legislate for it, I can only produce what is my experience and produce what it is- the client's experience.

3.5.5. FIFTH BRACKETING INTERVIEW

The final interview occurred when all the data were collected and analyzed. This interview revealed the emotional response of the researcher to the work.

Bracketing Interview 5-Final

P ...disseminating it onto paper, were you aware of anything, any process within yourself, from an emotional perspective that might be happening?

R Yeah, and I wrote a reflective piece at the very end of the last practice that I was going to and I was crying because mm... I realised that, mm... the places where I was going were sad, sad places (crying) and my experience is not that.

P So there is a whole depth of experience behind what you're seeing that is difficult to go into?

R (crying) well, I was on my own in the car and I just was driving around and it was so grey, and I could see hoodies, people in hoodies you know? going to different places, and I thought this is such a different scene to what I'm used to. I am in practice, I'm inside, I have a nice desk, I mm... the patient comes into me and it's my environment. But me going to their environment or even just driving through it, it's just a different world.

These bracketing interviews exposed the researcher's personal responses to the work in a novel way as it assisted in processing experience as data.

All bracketing interviews were audio-taped and transcribed and embedded in the research data. The potential for bias was laid bare and

the ideas, views and experiences of the researcher as practitioner and in the role of investigator with those interviewed were exposed as part of this process.

Other reflective material in the text such as personal reflective data written by the researcher in memos, field notes and journal entries were also interspersed with the data to identify further subjective responses to the process. This shed further light on competing and ambivalent positions experienced by the concurrent roles of practitioner and researcher.

Final Bracketing Interview

R I really think the bracketing process has helped because ... the researcher has come through quite strongly by the very end of it, not the practitioner... and it's set me on a different level now as a practitioner, I'm much more enquiring.

The idea of reflection in the bracketing interviews was not only to reduce the naivety of the researcher in relation to the constructed nature of data interpretation but also the main reason was to 'lift ' the project to generate more interesting, innovative and well judged interpretations and qualified results (Alvesson & Skoldberg 2005:286). This would not have been possible with a purely quantitative design. The researcher learned to see naively and freshly again, valuing the conscious experience, respecting the evidence of the senses. The addition of polyvocality enhanced the discourse throughout the text and enabled truth to be based on more than one form of data. Thus the study was allowed to move towards an inter-subjective knowing of things, people and everyday experience by using blended methodological approaches (Moustakas 1994).

CHAPTER 4: DATA ANALYSIS

4. INTRODUCTION

The goal of data analysis is to reach a place of understanding of the experience through the development of an integrated statement about the experience (Lavery 2003). The search for meaning, clarity and discrimination began at the outset of the analysis of the in-depth interviews. A description of themes informed and created knowledge of the essence of the MTP in general practice from the perspective of the service user.

4.1. ANALYSIS OF IN-DEPTH INTERVIEWS

The rationale for using a Husserlian phenomenological approach to data collection is given in Chapter 2. Giorgi (1969) Van Kaam (1975) and Colaizzi (1978) all have developed psychological research methods for data analysis based on phenomenology (Polkinghorne 1989). For the purpose of descriptive studies the steps espoused by Colaizzi are advocated for data analysis. The appropriateness of this choice of method is supported by several descriptive studies (Corben 1999, Baillie 1996, Koch 1995). Data collection and analysis are intertwined in phenomenological research methods and the researcher listened to the audio tapes as soon as possible once the interview had taken place and read the transcript simultaneously to acquire an initial feeling and understanding of the whole experience. The following procedural steps were then carried out in a disciplined way to produce a structural definition of the findings.

1) The transcribed interviews were read more thoroughly so that the researcher became immersed in the data (comprehending). This served as a foundation for the next step.

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Each transcript was imported into the software package NVivo8, which provides computer assisted qualitative data analysis software. Each transcript was assigned its own identifying folder and linked to the participant's voice which was integrated into the software and could be accessed and listened to simultaneously throughout the process of analysis.

2) Significant statements and phrases directly related to the phenomenon being investigated were identified, highlighted, extracted and transformed into the words of the researcher from these transcripts. The research question was constantly addressed to determine whether what the participant said illuminated and was relevant to the exploration.

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This was the first step of coding determined as preliminary coding. This coding process was expressed as individual free nodes (Appendix 8). Free nodes are a stand alone repository where broad, thematic participants' accounts are placed.

3) Then the researcher attempted to spell out the meaning of each significant statement (synthesizing). These statements reflected the essential point of the selected text.

4) These synthesized statements were collected and organized into further clusters of themes (theorizing).

Computer Assistance

This was the second step of coding expressed as tree nodes in NVivo8 (Appendix 9).

5) The individual themes were then clustered to produce a further reduction into general themes that were common to all the subjects' transcripts. Not surprisingly, some clusters overlapped and were merged, because this is a complex human experience made up of many facets, impossible to demarcate.

Computer Assistance

These themes were further broken down from tree nodes to child nodes. Tree nodes are similar to free nodes with two exceptions: They can have relationships with other nodes and thus may be grouped into themes. They can have 'children' and thereby have a hierarchy on these synthesized statements imposed on them (Appendix 9).

6) The researcher returned the transcript of the interview to the participants as soon as the verbatim transcribing was done in order to confirm whether it accurately reflected the essence of their lived experience as expressed at the time of interview (18 wished to read their interview). Two service users expressed literacy difficulties as a reason for not reading the transcripts. Follow-up discussion post reading of the individual transcript was carried out by telephone (15 responded to telephone calls). Any relevant new data expressed were worked into a revised final description.

Revision of the themes was an iterative process occurring as a result of continual reflection as the interviews progressed. The researcher moved back and forth between the meaning statements and the revised lists until the themes were accurately reflected in the clusters. The final

result of the zig-zag process was the finding of the research—the overall description of the experience expressed in four overarching themes and meaning units which provided the essential structural definition.

7) One further step which Collazzi did not carry out was to calculate the percentages of the occurrence of synthesized statements across the transcripts.

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At the outset it is important to highlight that frequency of occurrence of references does not equate with social significance of the topic (Bowling 2002) but is useful for the purpose of transparency and reader information and reference is made for each concept and meaning explored in the presentation of findings. This further progression in the analysis was made possible by the use of NVivo8.

4.2. DESCRIPTION OF DATABASE COMPILATION

NVivo8 is a specialist package developed solely as a computer aided qualitative data analysis system (CAQDAS) and is recognized globally as a reputable tool for managing and supporting this type of analytical work. NVivo has two principal benefits. These are:

- Efficiency
- Transparency

NVivo offers efficiency, because it allows the researcher to explore avenues of enquiry which would not be possible by a manual system as the amount of data generated from in-depth interviews is vast. To conduct a manual colour coding or cut and paste system places restrictions on time due to the sheer volume of exploration required. Such efficiency allows the researcher to explore the data in further depth and the inductive process was facilitated by total immersion in the

process of identifying the emerging themes. This allowed the researcher to rule out as well as rule in propositions or emerging hypotheses throughout the analytical process.

NVivo maintains a clear audit trail which facilitates transparency. The process and stages of coding are tracked in such a way as to facilitate the researcher in clearly demonstrating a rigorous approach to data analysis. These are demonstrated as screen dumps of free nodes, tree nodes and child nodes which display the in-depth analysis which was undertaken by the researcher (Appendix 9).

4.3. DATA SOURCES

The study endeavoured to collect rich and in-depth qualitative material in an explicit way. The concurrent analysis of data was facilitated by integrating the bracketing interviews, field notes, and memos. The reintegration of data from these interviews in the analysis stage exposed the personal values and judgments of the researcher. This unbracketing was an attempt to ensure that the researcher's personal suppositions did not affect the study adversely and added to the depth and methodological rigour. It also served to identify for the reader the life world of the research and the researcher (Stapelton & Taylor 2004). This model engages the researcher in a two stage process involving both thoughts and feelings, and utilizes two forms: a narrative form through conversation with a bracketer and a textual form that can also be analyzed and made available, as part of the audit trail. This lends authenticity to process and to the knowledge generated through it.

4.3.1. FIELD NOTES AND OBSERVATIONS

Observations from the field were recorded as field notes and text messages from the participants were noted as memos after the interview was completed by the participant. Linking memos to the audio sound byte facilitated a holistic approach to the data and meant the analysis was not conducted solely on the text from the transcript.

4.3.2. MEMOS

Memos served three purposes in this study. These were:

- 1) Giving Context to Sources
- 2) Generating Proposition Statements
- 3) Defining Nodes

1) GIVING CONTEXT TO SOURCES

A memo, setting out details of interactions with the participants gave context to the study. Memos from follow up interviews were physically attached to the transcript document and served to remind the researcher of the broad context of the research later in the data analysis process.

2) GENERATING PROPOSITION STATEMENTS

This process entailed noting memos that were attributed to individual nodes which helped in summarizing the contents. They served as preliminary drafts of the findings of the research.

3) DEFINING NODES

This was used as a process of tracking thinking processes. Memos were used to record the researcher's thoughts throughout the process of breaking down the data and defining all nodes. This assisted study

supervisors to clearly understand definitions. It also served to ensure coding consistency against such stated definitions.

4.3.3. DIGITAL DATA

Audio recordings from interviews were imported into the database which facilitated linkage of the transcripts to the text. This offered a holistic view of the data as the audio data added richness to the meaning and nuances in the text which were further illuminated by listening to the participant. In this way, important qualitative aspects of the data were captured. Emotion was not apparent through text alone. An example of this is when one of the participants discussed the fact that she had been treated poorly in the maternity hospital. She had tears in her eyes and this emotional response was linked to the relevant text in the transcript. The responses of the researcher during her final bracketing interview were emotional also and although pauses could be applied to text the reaction could not be noted in text alone.

4.4. QUERYING THE DATA

TEXT SEARCH QUERY

This enabled the listing of all sources that contain specified text. This provided a method of coding sources by facilitating a search for words and coding the occurrences at a particular node.

WORD FREQUENCY QUERY

This facility listed words and the number of times they occurred in selected items. Collating which words appeared most frequently helped to identify themes and concepts (e.g. the word “different” was mentioned 195 times with the majority of references made to how general practice was different to the treatment clinics).

CODING QUERY

This function gathered content based on how it was coded e.g. the content where women talked about methadone and their babies.

MATRIX CODING QUERY

This function created a matrix of nodes based on search criteria. For example, experiences and attitudes about general practice by gender.

COMPOUND QUERY

This facility combined text and coding queries when it was necessary to search for specified text in or near the coded content.

CHARTING

Charts were created to visually represent the coding data and to display matrix query results (Appendix 9).

4.5. RIGOUR

The rigour of the methodology is judged by unique criteria appropriate to the research approach. Rigour in the context of a phenomenological study can be demonstrated by ensuring the methodology is congruent with the philosophy used. In phenomenological research, bracketing, which has been incorporated into intentional focusing on the experience, is one factor that is central to the rigour of the study. In Husserlian phenomenology techniques such as bracketing, form part of the method of transcendental phenomenology. These processes allow an accurate interpretation of the phenomenon in the context of the prevailing philosophy (Seamon 2002b). Credibility, auditability, fittingness, and confirmability have been proposed as reasonable criteria for evaluation (LoBiondo-Wood & Haber 2002).

4.6. CREDIBILITY

The credibility of qualitative research depends on the use of credible data, a credible analytical process and a credible mode of presentation of the results. To ensure credibility, transcripts of their own interviews were shown to the participants. Each participant was asked to verify and comment on the interview and provide any extra information which they felt was relevant. This ensured that an accurate account of their experience was documented.

The transcripts from three of the interviews were analyzed separately by the supervisory team both in the pilot study and a further three in the main study. Similar themes were extracted and generated from this process and there was close agreement on the basic themes but each analyst may have 'packaged' the themes differently (Armstrong *et al* 1997). This afforded further credibility as Mays & Pope (1997) caution that research which relies exclusively on observation by a single researcher is limited to the perceptions and introspection of that investigator. Barbour (2001) asserts that the degree of concordance between researchers is not really important but what is valuable is alerting researchers to all potentially competing explanations. This was achieved by discussing both data construction and the analytical process with two supervisors. The use of an assistant researcher was beneficial and insightful to the method development and analysis throughout the pilot study and was used to prevent practitioner/client bias in the main study as it is debatable whether the researcher/practitioner may have in some way influenced the behaviour and speech that was witnessed in the first pilot interview.

Data consolidation or merging was also facilitated by NVivo to create new variables (not simply transformed ones) that were then investigated or analyzed (Kane *et al* 2001). This served to protect the narrative

structure of the data so avoiding the problem of de-contextualisation or data fragmentation (Mays and Pope 2000).

4.7. AUDITABILITY

The construction, data collection and analysis of data provide an auditable account of the research process. The inferences that have been made in the findings are supported by the decision trail of transformation of the raw data into phenomenological informed expressions and the synthesis of the transformed meaning units into the general structural descriptions. It was possible to present sufficient original evidence in the descriptive account 'to satisfy the skeptical reader of the relation between the interpretation and the evidence' (Mays & Pope 1996) by using NVivo as it maintained a visible audit trail (Appendix 9 Screen Dumps & Analysis). All processes and stages of coding were tracked in such a way as to facilitate the researcher in clearly demonstrating rigour. The descriptions of the participants accurately reflected their experiences and the influence of the researcher practitioner's bias was laid bare in the bracketing interviews.

Bracketing Interview 1

R Yeah, at first I think you challenged me that I was constructing the data myself and I didn't like that challenge because I felt, No!, this is a very open experiential type of research but in fact, yes, I had to look at that and realize that I was constructing the data-just by the very framing of the study and just also saying I wanted to 'tap into experiences'. So I found that very challenging, and in many ways I suppose it was the first line in the sand that I drew in the pilot study as Husserl says 'suspend the natural attitude' and come outside the process and look at it in a different way.

The transcription of data is accurate and has been verified both by participants, transcriber, and researcher. In the analysis of the transcriptions, conclusions other than those offered by the researcher

have been discussed in the findings (Polkinghorne 1989:57). The interpretation of a sample of interview transcripts has been undertaken by four independent researchers, namely the principal researcher, academic supervisor, practice based supervisor and the research assistant who was consulted during the pilot phase prior to embarking on interviews for the main study.

4.8. FITTINGNESS AND CONFIRMABILITY

The concept of fittingness refers to the everyday reality of the participants described in enough detail so that others in the discipline can evaluate the importance for their own practice. The data were voluminous and provided rich descriptions which will be useful to other practitioners and revealed context rich material so that practice and policy can be influenced and guided by the findings. Likewise the uniqueness of these findings may be transferable to other general practices and have impact upon service users and provide lessons for the discipline of nursing and other multidisciplinary professionals and settings. Components such as these are necessary to demonstrate confirmability which was facilitated and complemented by the use of NVivo8.

CHAPTER 5: FINDINGS

5. INTRODUCTION

Writing a story or poem is organic, synthesizing elements from the muddle of experience , weaving them to create a coherent artifact which communicates a seemingly single strand (Bolton 2005:39)- and so it is with the multiple experiences described by service users attending general practice for the purpose of methadone maintenance.

In order to honour the commitment made to service users and practice sites all place names, institutions, informant names and GPs names are disguised. Male to female ratio showed a majority of male GPs. There were a sufficient number of female GPs to ensure anonymity in mentioning their gender. The use of pseudonyms provides anonymity in the following reports from service users.

The data were analyzed using the methodology espoused by Collazzi (1978) as outlined in Chapter 2. Four themes emerged from the data.

These were:

- 1) Service users' experience of attending general practice for methadone maintenance.
- 2) The significance of methadone for the service user.
- 3) Service users' understanding of the MTP.
- 4) The experience of addiction and it's effect on families.

Each theme is discussed as a separate finding.

5.1 THEME 1

SERVICE USERS' EXPERIENCE OF ATTENDING GENERAL PRACTICE

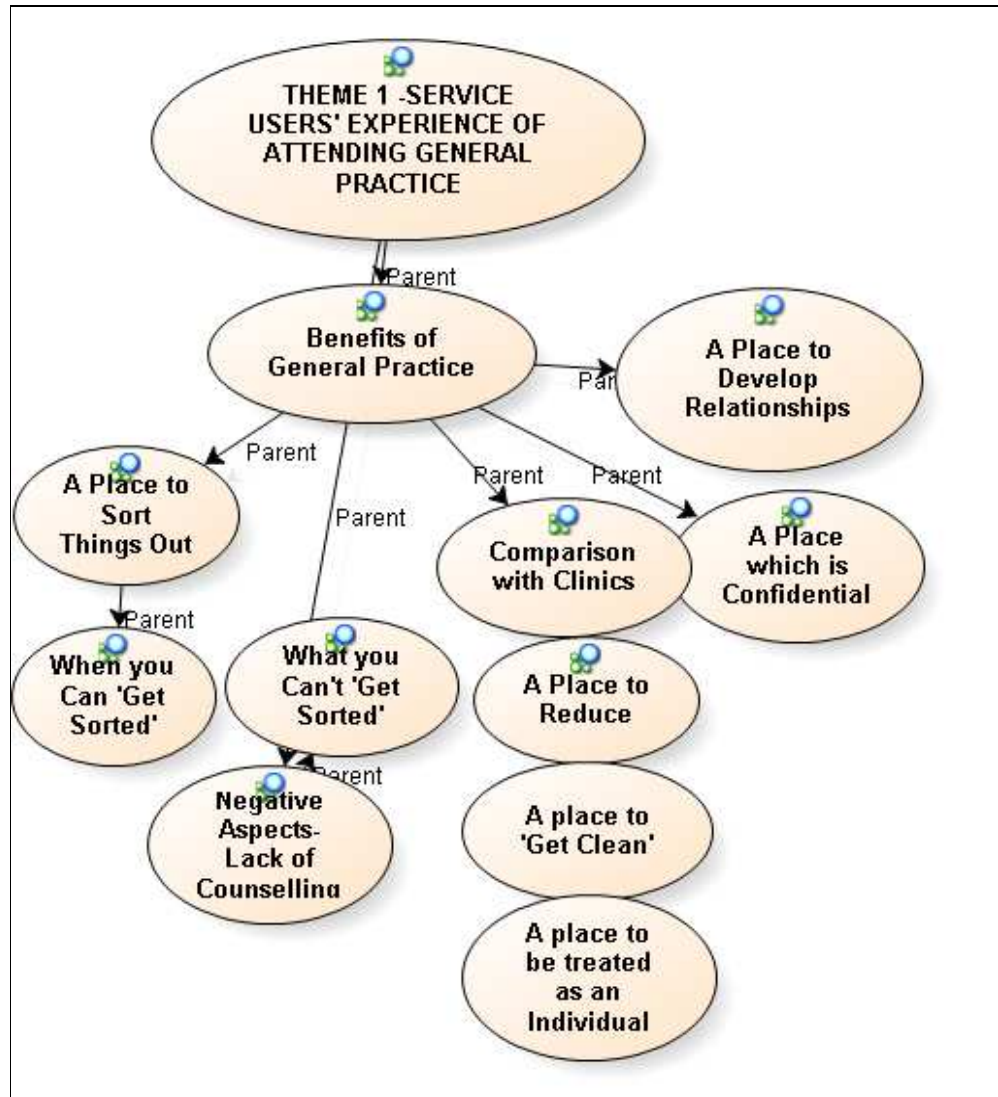


Figure 1 Theme 1 Service Users' Experience of Attending General Practice
(NVivo Model)

5.1.1 SERVICE USERS' EXPERIENCE OF ATTENDING GENERAL PRACTICE

This major theme was derived from the developed themes in which the participants described their experiences of attending general practice as a service user. These experiences were explored both within the exemplar of receiving methadone treatment and the perceptions service users shared in relation to general practice as a whole. Significant statements and phrases directly related to general practice were identified by analyzing the 25 in-depth interview transcripts. There were 106 significant statements from 23 sources which pertained to service users' perceptions of the benefits of attending general practice (these were expressed and collated as free nodes (Appendix 9 Screen Dumps). The transformed meaning was further broken down into distinct meaning units which were attributed to the lived experience of service users in general practice as opposed to the experience of attending a treatment clinic. These fitted into certain 'known' categories by the researcher but the experience was described beyond the knowledge of the practitioner – Bolton (2005:12) calls this genre of writing as 'writing beyond what you know, starting at the known part and writing into the unknown; that is where the service user describes that part in their own language. In presenting these findings the technique of polyvocality is used to explore practitioner bias. Excerpts from bracketing interviews are interspersed with the data and bracketed within margins within the discussion of the findings. ICGP guidelines are also displayed where required within margins (highlighted in green).

There were 84 references from 22 sources relating to clinic services. The overall description of the experience in general practice was described by the majority of service users as a comparator to past experiences within treatment clinics. Although no specific question was asked about the treatment clinics the experience featured highly in the

majority of service users' accounts. Key aspects of attending general practice were identified as: ***a place to be treated as an individual, a place to get clean, a place which is confidential, a place to reduce, a place to develop relationships and a place to sort things out.***

5.1.2 KEY ASPECTS OF ATTENDING GENERAL PRACTICE

General practice was consistently described throughout this derived theme as a 'different place' ***and a place to be treated as an individual.*** There were 31 significant references from 15 sources identifying the importance of being treated as an individual in general practice. The frequency of the word "place" was mentioned 114 times and the word "different" 195 times. The majority of service users expressed their preference to be treated in general practice. In the following descriptions the service users describe the difference.

Daithi *but in a clinic ...'cause they treat you all the same, you see, they see so many drug addicts in there that they paint them all with the same brush you know?....in a clinic it's completely different than a GP practice, you know ?*

The experience in general practice however was highlighted as being different to this.

Craig *... like you're not treated like a ... like a ... you're not treated... here (in general practice) you're not... they don't treat you like you're an outcast,*

Sean *eh, the dread of going down there,(Treatment Clinic) the way you were treated, to start first of all by the security guards going in like you would be going in there day after day after day. (General Practice). Much different, much difference, much more friendly eh which makes it much more easier for me to open up and tell you if I've had a slip or tell you if something has gone wrong or whatever you know?*

These accounts emphasize the institutional environment of the clinic and the highly regimented mechanisms in place for managing security. There were 36 references from 18 sources describing how the treatment clinic had never been perceived as a place to become drug free in contrast with general practice. The following descriptions focus on the importance of treatment context as general practice is viewed by the service user as a **place to get clean**. This place was described as a setting where it is possible to have a plan to separate from the environment of attending a treatment clinic and the peer pressure exerted by other drug misusers which is inevitably a deterrent to becoming heroin free.

Sean People nowadays and going back years, they never seen (the clinic) as a place to get clean... People stand around outside offering you drugs, offering this, so you have none of that (in general practice) and that is a good thing.

Padraig cause it's all around you isn't it?

The importance of treatment setting and environment was a perspective which was also shared by professionals as the following extract describes:

Erica I think I was only down about a year and ehm the doctor down there (in clinic) he was kinda saying because there was a lot of stuff going on outside after the clinic, you know? swapping things and selling the stuff ...and he said to me, you will start doing stuff if you stay down here and he said he would try Dr.X as he said he would try and get me a GP in the area.

The importance of confidentiality in general practice was also seen by the service user to be of significant benefit to them. There were 86 references from 23 sources emphasizing that this setting was conducive to privacy and a **place which is confidential**. Comparing the setting of the GP surgery with that of a treatment clinic the issue of

loitering which takes place outside a clinic was described. Entering a clinic and entering a surgery the following comparisons were made:

R *I'm interested in your views on what it is like to come to the GP?*

Rhiana *I find that it's more private, you know, people don't know your business because you can be here for anything like? ...the flu, whatever you're here for, you feel normal.*

Attracta *you're not picked out ...you're not just fingered cause you're... it's your normal GP do you know what I mean?*

Field Note re Attracta

She was apologetic in her approach to being interviewed at first, frequently tearful.

Padraig *What happens here stays here you know what I mean? It doesn't go any further.*

The significance of this discreet confidential service in relation to employment was highlighted by the following participant:

R *And confidentiality is important to you?*

Daithi *Yeah particularly if you're working, if you have to hold down a job which a lot of drug addicts, like meself they can work and...if their employer found out they were on methadone to tell you the truth they probably wouldn't get a job.*

Although the value of confidentiality for the service user was defined as beneficial within the confines of a consultation with their GP, there were significant limits to confidentiality. Three service users described the reception area as a location where standards were lowered. It was obvious to other patients in the reception area why the service user was attending and service users described how other drug misusers who attended the same practice knew why they were there.

Olwyn... it's (ha ha) mad cause people know what days you get your phy on.

Helen...and people are meant to stand back to keep it confidential like confidential but they go to the wrong folder and the folder with the methadones are kept in a red folder and I have to say, no, it's that folder and everyone up in (the locality)... I swear to God everyone knows the red folder is for methadone. So my friend she says did you ever see them up there like? people call it 'getting the red folder' and all like, they know well, they're on Methadone and I'm .like...yeah... and I'm one of them.

General practice was identified as being potentially beneficial in two important aspects of treatment-reduction in dosage of methadone and control over treatment. Meaning units derived from 112 references obtained from 24 sources described the treatment context as **a place to reduce**.

The ICGP guidelines advocate that once a level of stability has been reached the patient may wish to consider working towards abstinence by slowly reducing their methadone dose over time. The advantages of reductions in methadone when on maintenance can be planned and each successful step helps to reinforce progress and boost self esteem (ICGP2008:21).

The experience of those who were reducing in dosage and had a plan to reduce is described in the following extracts:

Sean (10mls-reduced from 44 in the last year and stopped taking illicit benzodiazepines) I will work myself right down to the two and then I will stop.

R If you wanted to go up on 60 mls or if you wanted to go down? Would you be able to say it?

Daithi (60mls) Course I would, I could discuss that with me doctor yeah, I have.

R: Have you done that?

Daithi Yes, me doctor has in the past upped my dosage and at times I've asked him to put it down and other times I've asked him to increase it, and he has done it yeah, that's no problem.

Sibh (32 mls) *I'd never been where I am today only for coming here. I was on 80 mls and they wouldn't let me come down (in clinic)...I was on Triptazole and they wouldn't take me off them, they wouldn't help me to come off them ...and I wanted to come down. And I came here and they gradually have done that now in the four years that I have been here!*

There was however dissent to the notion of who has 'control' over reduction from three sources. Some of the service users explained that there were buying extra and also using other illicit drugs. The methadone dose ranged from 20 mgs to 150 mgs in the sample (Appendix 7 Table 13).

Erica *I don't think the patients have as much choice as the doctors seem to like to think that they have!*

A misconceived readiness to reduce or have control was also apparent as the nature of poly-drug misuse appeared "chaotic" to the researcher:

Niamh (150mls still using heroin & cocaine) *I was offered up up up up I tried to say no I don't want to go up...(doctor) you're going to have to go up you need your life on track you can't go round smoking heroin so I went up..... look it I'm just going to say I don't care how Christmas goes whether I come in with a dirty urine with gear, crack, coke whatever I don't care, come January I was only told about of my charter of rights about this the other day I didn't know about it, I want to detox in January and get... I'm going to lay down the law, I want to reduce and I am going to start reducing from that day.*

Olwyn revealed how she feels she controls her methadone dosage:

R *Do you feel you are in control of your treatment or do you think (doctor) is in control of your treatment?*

Olwyn (Prescribed 90mls- takes 25 and sells the rest) *well at the moment I am you know what I mean?*

R *I do!*

Olwyn (*ha, ha*) *at the moment I am but that could be very easy, that could be very easily taken away like*

R *to change?*

Olwyn *like if I was put on dailys tomorrow that's... my control is gone*

R *OK and if you wanted to, suddenly you went in and you came clean and said look I'm on 25 mls, I want to go down to 25 mls do you think (doctor) would do that for you?*

Olwyn *automatically*

These responses demonstrated that reduction strategies are available in general practice and there is potential for service users to have control over their own methadone dose. However the service user can manipulate their dosage for their own benefit.

5.1.3 THE DOCTOR/PATIENT RELATIONSHIP

All service users described the doctor /patient relationship and 182 references to the concept of relationship were made from the 25 sources in the study. There were voluminous data and these responses were further broken down from tree nodes to child nodes which identified both positive and negative experiences. Overall 100 references from the 25 original sources indicated that although there were some negative experiences in relationship building the overwhelming picture was that general practice provided service users ***a place to develop relationships*** and the majority acknowledged a good relationship with their own respective GPs. Twelve sources recognized negative experiences. These were expressed in relation to past experiences with GPs and what service users understood were their present relationship with GPs in general.

A) POSITIVE RELATIONSHIPS

Positive relationships with both GPs and nurses were discussed. The relationship with the GP was central however and the benefits of

continuity of care in general practice were explored. The following descriptions emphasize the importance of the relationship with the GP.

Seamas *I've known him (GP) that long like we seem to nearly grow old together like... so it seems like ... we've grown up together in a different way you know... I've been here probably fifteen years with him,...I wouldn't see anybody in the week or the only person I'd see would be Dr.X I call him (Christian name) and I actually felt a lot better walking away like he does... he's a caring man.*

Robert *Well I kinda bonded with (GP) than any other doctor I ever done...*

Niamh *he (GP) knows by looking at me, I have to say I have a great relationship with the doctor*

R *yeah, it seems to be... tell me what that means like what does a great relationship mean?*

Niamh *like I can come in and say to my doctor look it I'm just fucking pissed off, what the fuck is wrong with me? I'm like a bull all the time you know? and I ... But I think he actually appreciates me doing that and being honest with him you know?*

This relationship involved being listened to, being heard and valued-a therapeutic relationship.

Daithi *Oh no, no, I wouldn't be here otherwise, on me life, I've built up the trust now the doctors you know I could come in here and talk to them about basically anything and they're genuine they listen to me ... I come in here and you'd talk and he would listen to you, to me and another time you just want to come in to talk like and you'd be listened to.*

Rosin *...She'd sit there and she asks you and she listens to you, what you have to say and she gives you that's it... and that to me meant an awful lot, right, that in itself is a cure you know what I'm saying?*

However this relationship has the potential to become complicated as highlighted by two service users when they disclosed to the service providers that they had bought extra methadone.

Anastasia *it wasn't that I was afraid to tell them (doctor and nurse) but I didn't know what way but I did tell them in the end... I think I was on something like 45 mls, I like couldn't handle it you know like? So they brought me back up to me 60 and they said if you ever have any problems again, tell us, don't go into your own little world and just, you know what I mean?*

Bracketing Interview 2

P what sort of personal challenges apart from the clinical side what's going on there? what sort of personal emotional challenges are coming up for you?

R I think the emotional challenge is this constant internal discussion about the reality of the experiences of the drug misusers and the reality of my experience looking after them.

This extract details the frustration of the researcher when something like this happens in practice. The service user finds it difficult to trust the professional and the professional in this instance is striving for a more mutual trusting relationship. Overall these responses identify the importance of relationship building within the framework of methadone treatment.

B) NEGATIVE EXPERIENCES IN RELATIONSHIPS

There were however details of negative experiences elicited. The following extract reveals a dichotomy in this service users' approach to relationship:

R *So you were never on a clinic?*

Erica *I used to be.*

R *Years ago?*

E *Years ago and I was treated like a dog.*

R *So you thought general practice would be different to that anyway?*

E *I was hoping so, well I knew (says name of GP) and I knew I would be respected.*

Despite references to feeling respected the following extract described a divide:

Erica (80 mls continues to use heroin, cocaine, benzodiazepines and extra methadone) *Well it is a bit different to being a patient of a doctor. Ehm, it is a little bit like us and them. It is a little bit, yeah... It's a bit sad that they can't say that to the doctor that they haven't developed a relationship with the doctor and that, that's the way it has to be.*

Erica described the experiences of other drug misusers and elaborated on her current relationship with her doctor. This relationship was expressed positively but there was evidence of previous mistrust when relating to doctors.

Erica *Coming here, it's grand, it's handy. It is a lot more personal than going to the clinics. (GP) She will talk to you till the cows come home. Do you know what I mean? She always says how are you? how are you doing and you're there kinda, is she in a hurry?*

R *and how does that make you feel?*

E *it takes a bit of getting used to, to be quite honest, yeah it does actually. ..Like the way I had never experienced doctors, you know that way...if the relationship was different if you had, like you're going back years here, of very very bad treatment. You're going back to (original treatment centre) and the older crowd are telling the newer crowd 'don't trust them' you know what I mean? So that's going on!*

R *So there is a kind of culture there of mistrust?*

Erica *There is, yeah there is...and an awful lot of crap has happened do you know in (names Treatment centre) and I'd have stories meself and all ...*

R *Do you think general practice is different to that now?*

E *...oh I would*

R *Or your experience here?*

E *Yes.*

Relationship issues were explored further by three participants when they found their own GPs would not look after them for methadone maintenance. However there was an ability to renegotiate and find another GP for MMT.

Daithi... *if you can't go to your own GP and get help who can you go to? So I had to go out and find another doctor to take me on.*

Rosin *yeah well I had a GP in (locality) and as I said I was breaking my head off the wall trying to get on the Methadone programme.*

R *and your GP didn't do it?*

Rosin *and he was a quack basically right ...so I said I have to get off this man so.*

R *He didn't help your drug addiction at all?*

Rosin *No he didn't whatsoever!*

R *Did you have a GP like for your normal kind of health issues?*

Ken *Yeah I had a GP and when I went to him about me drug problem the first thing was – I can't give you methadone, I can't give you any sleeping tablets.*

Definitive negative responses were elicited from three participants who described a very rushed consultation pattern with their current GP methadone prescriber. This pattern was recognized during the pilot phase and described by the following key informant:

Sean *Some doctors they come, in they get the sample, they look at it yeah, grand right there's your script... go! you know what I mean? Out!*

These observations were confirmed by the following three responses:

R *Like would you just think that what you say is important to her?*

Helen *No, no because (doctor) is just.... this is what (doctor) does (mimics looking down at prescription pad) oh what are you on again? I say 80 and what day are we? Ok, ok there it is come back to me 6 weeks now there it is!*

Tadgh *But the doctor doesn't really know like he's there to write a prescription and that but...*

R *And have you had that discussion with him, have you told him you're splitting doses?*

T *Aw yes he knows that I split the dose.*

I *And has he suggested that you don't?*

T *Well he doesn't... I don't think he knows too much about Methadone!*

He probably wouldn't know the difference like between two different tablets like he be the same with the Methadone like I don't know whether he'd know what it does!.

Olwyn *Yeah when I was younger so I would be always over there, I've known him since I was grown up kind of you know? what I mean like he's always been the family doctor.*

R *Yes that's what I mean, so tell me about being a family doctor what does that mean to you?*

Olwyn *It doesn't he doesn't mm ... things definitely have changed since... I've become his methadone patient*

R *Right tell me about that?*

O *I go in the door now and automatically it's just, check me urine and he's writing out a prescription and he's trying to get me out the door as quick as possible ... yeah like all he is to me, now phy to mewrite it down ...push it across see you next week...! Yeah he just automatically assumes that once you're come in you're coming in for your phy prescription and nothing else.*

Bracketing Interview 4

R *So what they use the doctor for has been informed by partly what we do (GPs & Practice Nurses) and partly by the fact that they have no expectations of care beyond that Methadone script?*

This response identifies that the researcher is beginning to understand how professionals can prevent full engagement on health issues and deflect opportunities to discuss treatment issues within the confines of a methadone consultation. Opportunities for full engagement on other domains of health are missed which should usually be addressed within the confines of regular GP consultations. These descriptions highlight the potential for two very different relationships which can develop when the service user attends general practice.

5.1.4 ACCESS TO SERVICES IN GENERAL PRACTICE

Service users described the services available to them when they attended their GP. General practice afforded them ***a place to sort***

things out. There were 127 references extracted from 23 sources where research participants referred to what was and what was not available for them when they attended their GP. These were further broken down to identify service structures such as appointment times and services provided by the medical team. These were described as **when you can get sorted** i.e. appointment times and availability and **what you can get sorted**. Lack of services are described as **what you can't get sorted**.

There were thirty four references from 15 sources discussing appointment times and **when you can "get sorted"**. All attested to the fact that they knew when they were to arrive. In general, appointment times suited and the majority complied with the surgery structure.

Ken *Yeah, I have me own time you know what I mean, I have me own time to come in and sort things out.*

Only one service user was negative about attending weekly.

Erica *I think it's ok but like every week fifty bleeding -two weeks a year!...I do think it's flexible all right but like I work and I have to turn down some parts of my work so that I haven't got it on (says day of week) morning.*

ICGP guidelines on attendance: Drug misusers on methadone should be seen regularly for review. The frequency of review will depend on the stage of their treatment programme. (ICGP2008:22)

There were 98 references extracted from 23 sources describing the services provided in general practice as **what you can "get sorted"**. Services which were described ranged from care for minor illness, child health, womens' health (smears and coil insertion) asthma checks, health promotion including weight reduction, advice on hyperlipademia,

phlebotomy and viral screening, investigations of infertility, antenatal, pregnancy and post-natal care, blood pressure taking, dermatology, flu vaccinations, childhood vaccinations and managing depression and back pain. Ten women and 2 men described using general practice as a place to have their children looked after. Overall there were 19 service users who had children (Appendix 7 Table 3).

Niamh *It's a place where you can bring your kids.*

Sibh *Yes if I'm sick I come, if they're sick, I come.*

AR *Oh you bring the kids as well?*

Sibh *Oh yes, he's the kids GP as well.*

AR *OK, so and it's fine for all that kind of thing.*

Sibh *Yeah it's brilliant!*

Olwyn... *but no all in all, it is a good general practitioners like, I can't say it isn't, like anything that I've ever needed I've got.*

Eleven of the service users spoke of the practice nurses in terms of seeing the nurse (7), talking with the nurse (1) and the nurse testing urine (3). "Seeing the nurse" involved phlebotomy, cervical smear taking, ante-natal care and urinalysis.

R *So what does the nurse do for you then?*

Olwyn *I'd go in and give her supervised urine.*

R *Oh she goes into the loo with you?*

Olwyn *Yeah.*

Saoirse... *when you go in (doctor or nurse) they spend the same time with a Methadone patient than they would with a non methadone patient. You know for different needs any thing like that but like they're very good and (Nurse) is great cause she reminds you of your appointments like, she was chasing me for the past three years for a smear test and she actually got it from me.*

Bracketing Interview 4

R I think one of the big issues is the under resourcing in general practice by the practice nurse and I'm disappointed because the original research which was started in 2001 when I went into practices and spoke to the practice nurses involved in the same general practices that I'm back in now, they felt they had a huge part to play. – This is further illuminated by the following extract

Masters Research: Informant 3 (69) You contribute, you're not just liaison because of their protocol, they're seeing you because they have needs and issues like every other patient ...you know its very much holistic care rather than... ehm they are not just methadone protocol.

This bracketing interview and previous research extract illuminates how although the nurse feels she contributes significantly to the care of the service user, the role of the practice nurse is viewed as one which is task orientated, providing services but not specific psychological care.

There were 59 references from 19 sources describing counselling facilities which revealed that there was a general lack of this type of service provision in general practice ***what you can't "get sorted"*** Although counselling was available on site in four of the practices and service users had access to services outside the practice in the community, it was a service need understood as being important when receiving treatment. Geographical boundaries affected access to on site counselling as highlighted from this extract:

Sean... *as I was saying its a bit ridiculous that I can't access a counsellor from here do you know what I mean ?even though I'm in (names locality) now ... that's the good thing about the counsellor I'm linking in with , he's an ex addict, he knows exactly what its like.*

There was concern that emotional well being was being overlooked.

Erica *...you get someone who has gone through misuse as a child and it doesn't have to be sexual misuse, emotional, physical, anything you like. It's stuff where they can't*

relate to people, they can't develop relationships, they are not socially capable of just communicating Going into restaurants and having a meal, that's not part of their life cause they find it difficult. General practice isn't helping any of that!.

R *You don't think?*

Erica *No, I don't think so I really don't! And I think there should be a way of incorporating that into methadone treatment.*

Even though the relationship with GPs was considered to be good it was considered by all who described their experiences that counselling was a service which provided a specific need whether they wished to attend or not. This need was considered to be outside of the remit of the GP.

Craig *Like I'd started talking to (doctor) what I'd started talking to the counsellor about, I started off talking to (doctor) first like (doctor) acted as a counsellor first, for me problems and all...*

Daithi *Yeah I went to counselling myself separately; I never used my GP for that.*

R *Do you have counselling here?*

Niamh *No, in the community drug team.... yeah I can talk to the doctor but I wouldn't go in and deep and talk to me doctor but I do find I can talk to me doctor, which is good but also the doctor doesn't have the time to sit and talk and listen*

On site addiction counselling was available for Craig who revealed:

C *'I'd rather that time kill two birds with the one stone'.*

Field Note re Craig

He was uneasy at first but then settled down during the course of the interview and began to engage with the process of telling his story.

Difficulty was expressed in accessing counselling in a treatment clinic as this means that the service user has to re-engage with this environment and other drug misusers to attend.

Tadgh *No, there's nothing here like you have to go down to see the... you'd have to go down to (clinic)...but that's where they go for the phy, all the worst of the worst go there you know that way?*

This overall description of “getting sorted” describes the users’ perception of what services are provided for them in general practice. The slang of “getting sorted” is often also applied to the process of obtaining heroin.

SUMMARY

The findings of this first theme described service users’ lived experience of attending a GP for methadone treatment. The overall description of the experience was described by comparing past experiences within treatment clinics to present experiences in general practice. The transformed meanings were expressed as ***a place to be treated as an individual, a place to get clean, a place which is confidential, a place to reduce, a place to develop relationships, a place to sort things out*** and ***what you can't get sorted***. These findings will be discussed further in chapter 6.

Bracketing Interview 5

R They knew that this was a different place, their identity would change almost by going into general practice.

5. 2. THEME 2

THE SIGNIFICANCE OF METHADONE FOR THE SERVICE USER

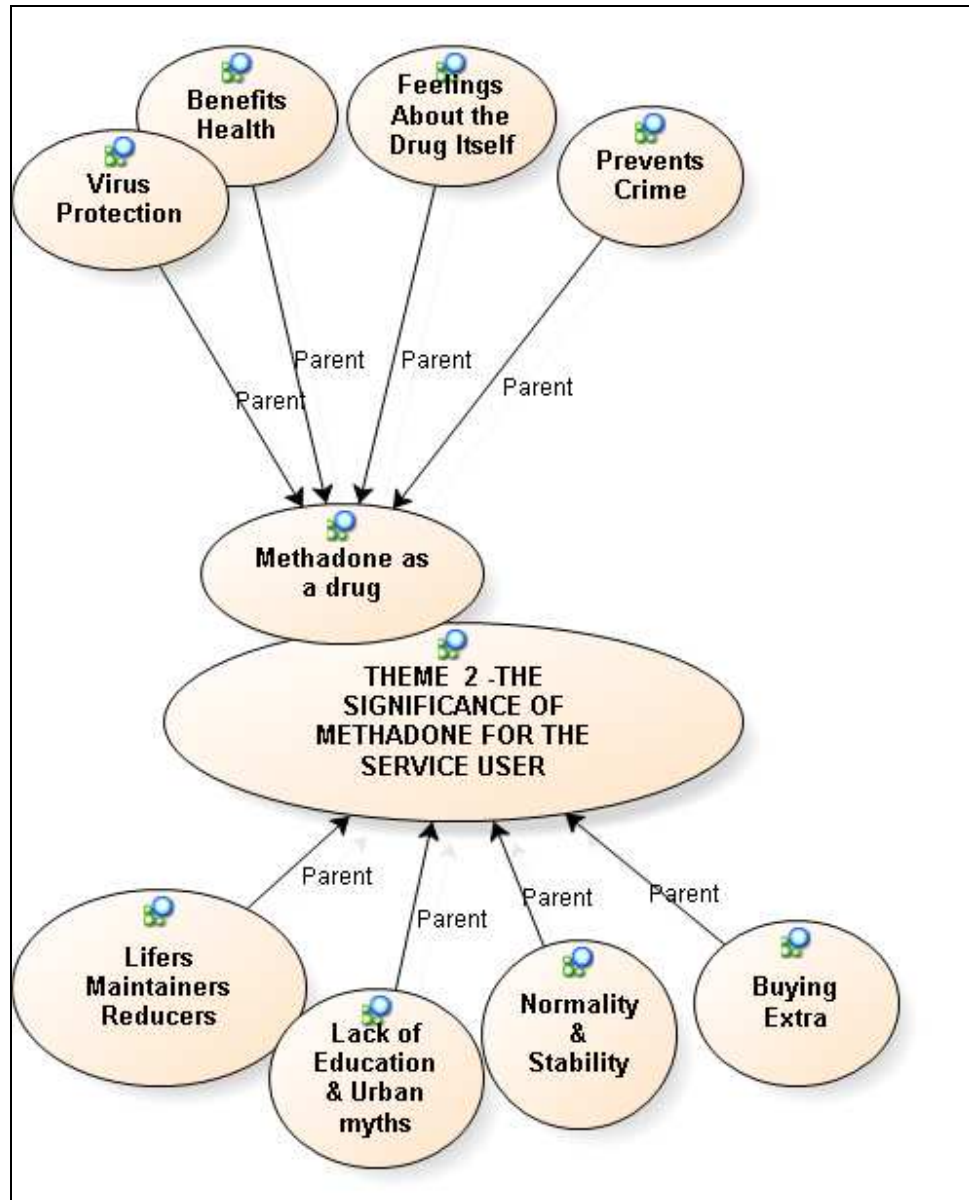


Figure 2 The significance of methadone for the service user.
(NVivo Model)

5.2.1 THE SIGNIFICANCE OF METHADONE FOR THE SERVICE USER

This theme was derived from the developed meaning statements where service users described their lived experience of methadone and the significance it has in their lives. Methadone as a drug and its effect on their lives was described in various ways. Meaning units derived from the data were: ***what methadone does for the service user, what methadone means to the service user, how methadone defines the service user and the importance of street trading.***

5.2.2 .METHADONE AS A SUBSTANCE

Descriptions derived from 131 references extracted from 22 sources pertained to the experience of taking the substance of methadone and how service users felt methadone affected them. This was described as ***what methadone does for the service user***. Strong emotions were expressed about the drug itself as these extracts illustrate:

Erica (80 mls continues to use heroin, cocaine, benzodiazepines and extra methadone) *Yeah I just hate the drug, I fuckin hate it! God forgive me, I fuckin hate it!*
R *Would you suggest that you prefer heroin?*
E *Yes, I don't get stoned... I take heroin, I took heroin before I came here do you know?...No it's the bloody drug! It's just so much harder to get off then heroin...I think there's a market after just being developed!*

The addiction to the substance of methadone was described by Sean:

Sean (20mls) *I actually despise it, yeah I do I genuinely despise it, taking it every morning, every morning I get up and I'm taking it and I'm like, you know what I mean... why?*

Positive aspects of the substance were also described and the overall benefits of methadone were highlighted by 15 sources with 24

references attributed to the beneficial aspects of either the substance or substitution therapy.

Anastasia *Like I honestly believe that Methadone saved my life you know, I really believe that one hundred per cent you know because ehm, I just don't think I could of got off drugs without it.*

Daithi *I mean the methadone programme, that I mean, it basically changed me life you know what I mean? it gave me back my life, it meant I could hold on to me job, I could work.*

The other benefits of methadone were attributed to what the participants believed to be health outcomes. The following extract illuminates a perceived benefit of maintenance:

Robert *Well I think it's like this!, if I was going to give up methadone now and be as clean as a whistle I'd end up with toothaches, back aches, eh your stomach not being able to eat, its not withdrawals, its not withdrawals, like, its just old injuries because when you take your methadone all them... old injuries kinda go away you don't feel them.*

Overall the majority of service users were positive about the effect methadone had in transforming their lives and lifestyle.

Seamas *I've come in here now, a lot of the lads now that would have been pretty bad years ago, they'd have cars now, they have girlfriends, they'd be looking well, their teeth and they keep themselves clean. Whereas years ago they would have been rampant heroin addicts you know?... I was just sitting here now (sitting in doctors chair) picturing me there (researcher sitting in patient's chair) now eight years ago, my life was a crock of shit! and if I'd have been the doctor I'd have been thinking, that sort of man is capable of doing anything when he goes out that door!, I don't know what he's up to but yet, if I give him this prescription, it's somehow handling him and somehow going to do something.*

Crime reduction as a direct result of methadone maintenance was identified from 7 sources with 21 references related to criminality. Eight of the sample reported that they had been in prison with 13 admitting to past convictions. The following extract details how methadone has been beneficial in preventing further crime.

Seamas *...yeah the likes of meself, I was in (says name of prison) prison and the worst prisons and I've done some of the worst things you know in prison and there's no doubt I was capable of some crazy shit and when I started on the methadone that's all not going to happen...eh like people in the neighbourhood would notice me not running around with balaclavas jumping in and out of cars stealing, you know...? ...me, the doctor and everyone else that's in this place ...we would've seen people coming in here about 8 years ago , swallowing bullets and being chased all around the country by police in an awful condition , coming in all cleaned up and looking well and they'd be going off to work!.*

One participant attributed being involved with a GP within the context of a methadone maintenance programme as a way of reducing the possibility of contracting HIV:

Padraig *I said Id be HIV positive only for him!*

However 3 participants who were HCV positive described both the treatment received and education given for HCV while attending general practice.

Ado... *but I'm saying like the heroin, you know, like cause I used to always have the needle you know? like a brand new needle like, the doctor said you can get it like from the spoon you know?...He said if I was squirting it through there onto the spoon...straight onto the spoon and stuck on that... it never even dawned on me that, didn't you know like? and he said it to me.*

One of the service users who wished to stay connected with the study provided poems- the following one describing his views on how HIV is contracted.

5.2.2.1.

A BULLET IS QUICKER

*At the start it is just a game
Everyone else is doing it why should you feel shame?
Get the foil chase the dragon
After a while nothing happens*

*Injection is next on your mind
But you can't get a vein of any kind
So your mate gives you his syringe to get a hit
After a while you feel like shit
Darkness falls but the cravings awake
Your stomach, back, legs and head ache
You go out to find a cure; even then you are not sure
A stranger offers you a hit, you use his works, you don't give a shit*

*Suddenly you are catching colds and flu
You think they'll pass but they never do
You're not eating, sleeping, don't feel well
You are in a living hell*

*You go to your doc with a cold and a sneeze
Then he tells you, you have a serious disease
You can't believe it; you fall to your knees
So be careful whose needle you share
Look out for yourself and take more care
Cause before you know it we will be offering you a prayer*

There were 8 references from 15 sources describing both what the service users understood about methadone and any education they had received about the drug. Thirteen service users identified the phenomenon or urban myth of the substance "getting into your bones", 1 did not believe it affected bones while 3 identified this to be the reason why they perceived methadone withdrawal to be so difficult.

Molly... *and I'd always heard that methadone gets into your bones*

R *Has anyone ever given you information on methadone?*

Molly *No*

R *The information you are getting is from other...?*

Molly *Yeah it would be from my experiences and from, I know people as well.*

There were inaccuracies expressed about the effects of methadone from a number of sources.

Robert... *you know what I mean? so that's what people were thinking, it dries up or you know the way there's supposed to be wet in your spine or something fluid ?*

R...*cerebro spinal fluid?*

Robert ... *yeah its (methadone) supposed to dry that up or something?*

Saoirse *Yeah I think that definitely the methadone in the long run, if you're a long term methadone user that it can actually bring on suicidal tendencies in people.*

Where information about methadone was obtained varied. Three had received written information from their own GP, 1 from the pharmacist and 2 spoke of the expertise of the nurses in the treatment centre.

R *Have you ever been given any books on methadone?*

Robert *Yeah I was given, he (doctor) gave me a book straight away, it was one of those green books...*

In general the lack of education received was described in the following extracts:

Niamh *Yeah like everybody, I'd make sure that everybody was fully aware of the consequences of going on methadone.*

R *Ok tell me about fully aware of the consequences, did you ever get any education about methadone, did you ever know what methadone did?*

Niamh *no, I knew it was just... if you had no gear. you'll get a sup of phy you'd be all right*

R *Even though you set up a service users group?*

Niamh *...oh them, oh that's oh I knew like enough about methadone and I knew like when you were on methadone it was really hard to come off it, and this is why the services users' forum they set up was, because we wanted to have answers from the doctors you know like... why..? Is there anything we can do to come off the methadone? and basically the only answers was, go with the treatment, come off the methadone, detox and go though your sickness-out of here.*

5.2.3 WHAT METHADONE SUBSTITUTION MEANS TO THE SERVICE USER

Methadone substitution emerged as important in terms of how service users' lifestyle can be transformed due to treatment. The meaning attributed to methadone substitution was consistently one associated with both ***normality and stability***. There were 119 references from 25 sources describing the benefits of consuming methadone. This was perceived as a way of feeling "normal and stable" as the following extracts illuminate:

Saoirse *... for many people it's like a security blanket you know, it's something they can fall back on and something they do not want to let go... but like methadone is good in many ways, like it gives people who have been on heroin it gives them that stability ..*

Kaitlin *Yeah, and then after when I was stable I found that when I stopped doing gear I settled...I could actually think and function properly you know? you know I could be*

reliable... you know? I actually started going to ...this course and I loved it ...I was on methadone and that's how I got into college through that.

Field Note re Kaitlin:

She seemed determined to change her life and slowly reduce her methadone.

Niamh (150mls still using drugs erratically)... *it helps you get structure back in your life but... it helps you get your old one off your back, do you know what I mean? I know people who are saying, I'm going on that phy, that old one's doing me head in, they don't want to be on it but just to shut their ma's up.*

R... *and what does stability mean to you now?*

Cara *To get up in the morning, to get your daughter out to school.*

R *So what does methadone help you with?*

Cara *ehm... I have a life.*

R *That's interesting, tell me what you mean you have a life?*

Cara *eh I just... I can get up in the mornings, I can get me daughter to school and I can go out and do a bit of work, I can come home, I can even get the house done up a little bit you know so?*

Bracketing Interview 5

R...the significance of methadone is that it gets me "normal" and gets me "stable" and those words were used by them not by me.

5.2.4 HOW METHADONE DEFINES THE SERVICE USER

Methadone was described as a substance which defines the service user conferring a new and transformed identity from that of heroin addict. **Lifers**, **Maintainers** and **Reducers** emerged as categories related to the phenomenon of receiving methadone. These categorizations were both self defined by the participants and co-constructed by the researcher.

Bracketing Interview 5

P I'm just interested in this whole idea of the perception of the client as a "reducer" and you say heretofore you did not see them as that?

R No well I didn't see them as a category of person...but it became clearer and clearer and clearerwhere they saw themselves on that scale you know.

A) LIFER

There were 29 references from 10 sources describing a life long process of methadone maintenance. These sources described themselves and others as "lifers" or dependant on the substance of methadone.

Saoirse (80 mls buying extra methadone) *Yeah I know people that's on methadone thirty-five years you know and that's their life now you know? and one man, I think he's sixty-seven now but he's still on methadone, you know? and he can never see himself coming off because he's after been on it so long that... that's life!*

Seamas (140 mls 12 years in treatment) *well the bad aspect of it I'd class meself as a lifer!*

R *You mean addicted still?*

S *No, I'm a lifer, I'm going to be on this for the rest of me life, and I know that, I'm not afraid of it, I'm not ashamed about it or anything else and I don't care what anybody else, what they think. I look at some kids and I think they think there's a lot... they don't ... that it's not something that they're going to be on it for the rest of their life.*

Daithi *I'm taking methadone on a daily basis for 14 years with GPs and clinics and doctors and my body is chemically dependant on it...that methadone.*

R *There is one who calls himself "the lifer", I'm on this for life, I have no expectations of coming off and I'm actually... that's what I've accepted. And I think that's a sad model but I don't know how much more we can do about that?*

B) REDUCER

The term "reducer" was constructed from the service users' perception of their methadone dosage. There were 28 references from 13 sources describing this process.

Kaitlin (70mls buys extra benzodiazepines occasionally, 3 years in treatment) *I will be coming down. he was already bringing me down 2 mls and then I asked him to stop... He said he'd bring me down off the valium so I'm actually in the process of coming down.*

Rosin (70mls obtains benzodiazepines occasionally, 5 years in treatment) *... it's when I feel stable I'd usually come in and I'd say look... I'd like to drop another 5.*

Bracketing Interview 4

R these are the people who are taking control, we call them...I call them,"the reducers" because they are reducing right down and they have got it!They've got it but it is a long haul, getting them to that stage...It takes ten years for some people...! And then there's the small proportion of reducers and we have them and terrific stories and that's what keeps motivating me. People who've been on a huge amount of methadone and coming right down and maybe, responding hopefully, to the brief interventions that we have been doing with them. You know? challenging them about their behaviour...weeks upon weeks upon weeks!

This passage reveals the researcher's value judgments that reduction is a preferred goal rather than life long maintenance. Examining this attitudinal prejudice has resonance with the findings from the foundational study. This extract explored the practice nurses' opinions regarding methadone as a treatment option.

Masters study Informant 5...but they're still dependant on a drug , which you know I wouldn't be totally happy with,I would love to think you know, we were having a better success, that people were off it and not dependant on something.

C) MAINTAINER

Thirteen references from 7 sources described being maintained on the substance of methadone as "happy the way things are".

Cormac (5 years in treatment)... *it's further down the road you know but right now I'm happy, I'm after going through it, I'm after doing the treatment for me hepatitis, I'm after... you know and it's like giving up giving up giving up and like I feel like I need to take a break of giving up things you know?*

Anastasia (8 years in treatment) *yeah, well the thing is I'm very happy the way things are at the minute, in saying that I would love some day to be able to stop taking methadone, but at the minute I don't feel ready for that you know, I'm not ready for that, I know I'm not you know*

Attracta (5 years in treatment) *yeah it's keeping me away from all the people that are nearly mad because you get just a methadone person that is happy on the methadone, delighted to get their methadone.*

Bracketing Interview 5

R The other one is the patient who is happy the way things are and that's where I see the role of counselling hugely, the "happy the way things are", because they feel everything impacts on them. Life issues impact on them! family issues!, the fact that they have always been surrounded by death and suicide and horrific crime!. They're the ones that seem to be the most vulnerable in terms of need. They need an extra provision in general practice.

5.2.5 THE IMPORTANCE OF STREET TRADING

The importance of street trading emerged when discussing the significance of methadone in the lived experience of the service user. Methadone diversion, both in the buying and selling of methadone and benzodiazepines appeared to be enmeshed in the culture and rituals of receiving a methadone prescription. There were 91 references from 23

sources which described the implications of being on a methadone maintenance protocol and street trading.

Olwyn described the economic benefits of her maintenance dose as follows:

Olwyn (Prescribed 90mls- Takes 25 and sells the rest)... *yeah and then when I got me own place and that ,it's very hard to run a place on your own on the labour (social welfare) kind of so like the phy money, I rely on that money, to be honest ... yeah I wouldn't take phy like Tuesday, Wednesday sometimes I'd go to Thursday and mm it'd be just when I feel it when I start to get sweats then I take my 25 ...And because I have a house, I have me own home now so I have to keep me bills in order, the whole shebang you know, get me shopping and pay the bills, kind of ...*

Further incentives associated with remaining on maintenance treatment were described by Erica.

Erica (80 mls continues to use heroin, cocaine, benzodiazepines and extra methadone) *Ahh... I could have 1000 but at the minute I just have 700 I count it at the weekend ...I've loads of methadone at home. No, come here and I tell you most of the people who are doing very well who are still on 100mls and I'm telling you this and its not a word of a lie, they're selling their methadone, the incentive there is to be, ehm, all drug free, get your two weeks methadone and sell most of it and take thirty a day and there are hundreds of people out there doing that, right?*

Obtaining extra methadone and or benzodiazepines appeared to be relatively easy for those on maintenance (Appendix 7 Table 15).

Darragh (80mls): *but I know of other people ... and they can go in and say, in other doctors, they can go in and give the sad story and get put up a little bit more (on methadone dosage).*

Attracta (80 mls+ buys extra benzodiazepines)... *just down there at the (names area in locality) and mm if you wanted to go down there you could get extra tablets, your extra dalmane or whatever...yeah, yeah, right opposite, the minute you see*

anybody coming out of the chemist they'll either do that (gives a nod) and say go round the corner and keep walking or else!.

R *So you buy an extra 50 per week or 100 per week?*

Padraig (90 mls buys extra methadone) *140 some weeks!.*

Field Note re Padraig

He openly admitted to buying more methadone and was afraid that he would be thrown off his programme (he had negotiated a higher dose in the past).

Bracketing Interview 5

R Street trading of course is part and parcel of it so I mean that's a cultural issue as well. I didn't understand the significance of the street trading, I didn't understand the significance of the culture in terms of, this is what they have done and this is what they continue to do whether they maintain or not, whether they are on maintenance or not. The reducers are not involved in street trading.

SUMMARY

The findings of this second theme describe service users' experience of taking methadone as a substance. Meaning units derived from the data were: ***what methadone does for the service user, what methadone means to the service user, how methadone defines the service user and the importance of street trading.*** These aspects of treatment together contributed to the overall lived experience of being prescribed methadone and the meaning attributed to the substance and substitution treatment. These findings and the implications for practice are discussed further in chapter 6.

5.3 THEME 3

SERVICE USERS' UNDERSTANDING OF THE MTP

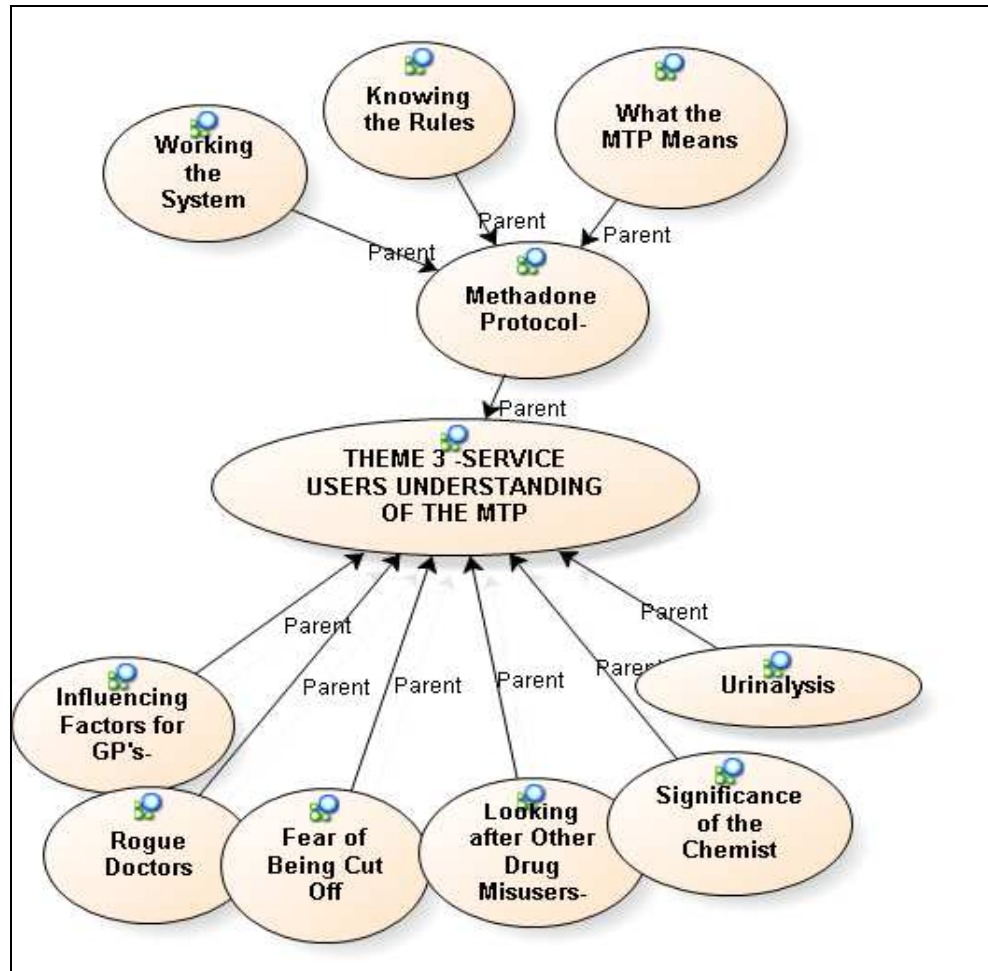


Figure 3 Service Users' Understanding of the MTP
(NVivo Model)

5.3.1 SERVICE USERS' UNDERSTANDING OF THE MTP

This third theme was developed from the meaning statements where service users described their understanding of the Methadone Treatment Protocol. Meaning units developed were: ***why the protocol was necessary, what the protocol means to the service user and understanding what influences the implementation of the MTP.***

5.3.2 THE REASONS FOR THE INTRODUCTION OF THE MTP

Service users described their past experiences with doctors who prescribed methadone on the black market. Within these exemplars the reasons service users attributed to the historical development of the MTP were explored from their perspective-***why the protocol was necessary***. There were 75 references from 21 sources describing service users' experiences both past and present with "rogue doctors".

These rogue doctors were described as "bogey doctors" similar to the colloquial use of this term which is used in the context of providing a false urine specimen. These descriptions identify for the first time in the literature the black market system which influenced the introduction of the MTP and also uncovers current practice.

Daithi *The protocol started in 1998 and basically what happened was doctors, certain doctors, were over prescribing methadone and there was a lot of methadone on the street and at that stage doctors were prescribing eh physeptone... but basically the eastern health board they wanted to take control of basically heroin and methadone, (how it) was going to be dispensed, they sussed out all the bogey doctors there was a lot of them giving out prescriptions just for the money.*

Molly... *but basically the Eastern health board, they wanted to take control of basically heroin and how methadone was going to be dispensed, they sussed out all the bogey doctors, there was a lot of them giving out prescriptions just for the money.*

Sean explained that the chemists were also affected by the rogue doctor system.

Sean *I used to know a chap who got two bottles per week, he was on with two different doctors, this was before the whole methadone protocol came in. ...like you could get a prescription, go into the doctor, pay the money under the table and ...he would write you a script and the thing about it was that you could practically go to any chemist and change it there and then people were going then like!.*

There were economic benefits associated with the "rogue doctor" system in the past and a chemist refund could be obtained when a certain amount of money had been paid to the chemist for a specific quantity of prescribed medication. This was considered to be a major economic benefit of the rogue doctor system and one that is no longer available.

Olwyn... *BUT nothing has changed really.*

R *Now that's interesting, tell me that, nothing has changed?*

Olwyn *Nothing has changed...the whole, yes like it might feel, like you mightn't be paying your forty quid, I think actually I would prefer back to the way it was cause at least you knew like you were paying your forty quid blah and you knew you were going to get that back in a lump sum so many months later.*

R *Like get the refund in the chemist you mean?*

Many such as Erica and Saoirse attested to the fact that they had sought out "rogue doctors" in the past:

Erica *Yeah, I used to hit loads of doctors to be quite honest. Ah some of them are mad, ah Jaysus... I hit on doctors.*

Saoirse... *That was the very first time I was on a methadone programme but he was like... he used to be drunk (ha ha)...He is not a doctor, he was struck off in '98 when the protocol came ... but he didn't care once he was getting the money like, he'd open*

a drawer and he'd have a big bottle of whiskey there, but next to the whiskey there'd be loads and loads of 20, pounds notes at that time like ... I think that turned me off like ...

Others, such as Olwyn, had a reciprocal arrangement in place:

Olwyn *there was a doctor that I used to go to now for me tablets and...he'd pay me to clean up the surgery and then he'd pay me in scripts... no I'd get paid in scripts!*

Helen and Cormac recounted current practice and how to negotiate obtaining a prescription of benzodiazepines or night sedation from doctors other than the methadone prescribing GP.

Helen (70 mls Obtains extra benzodiazepines) *(my own GP) she wouldn't give them (benzodiazepines) to me she doesn't like giving them to her patients, fair play to her cause everyone asks her for them but Dr.X. he wouldn't take me on as a patient, I have to pay him... but he'd give me them*

R *So she's not prescribing you your benzos and you're buying? You're going to do a private prescription with a private GP for €50?*

H *No I don't need to see him, just get the prescription...he doesn't ask why don't I bring the kids down or anything, he doesn't come out of his office you don't even see him like ...two a day, so every time I take the methadone I take the two.*

R *but if you did, if you had a chest infection which doctor would you pick to go to, you know what I mean, would you go to the one who is going to give you a prescription for benzos?*

H *oh I wouldn't go near him! I think he just does the prescription!*

Cormac *in this day and age yeah, there is a doctor in (locality) who gives it, drives a big huge car, you went in with €50 he'll tell you to make up an address in (locality) right,? (doctor says) ' if anyone asks you, you come in, you told me...you told me...you've only come over from England, you were working with a crew over there you'se were drinking all the time, you were on with a doctor you came in to me with a couple of valium in a jar and you were coming to the last of your Valium, you were clean off the drink, the valium is working for you the dalmane for sleeping and I took you on that way like...I write you a script... just take your €50...that's it!*

5.3.3 WHAT THE PROTOCOL MEANS TO THE SERVICE USER

The meaning of the MTP from the perspective of the service user was developed from a total of 140 references from 25 sources describing aspects of the MTP. These descriptions involved ***understanding the protocol, knowing the rules*** and ***working the system***.

There were 26 references from 12 sources pertaining to the service users' understanding of the MTP. Some service users had a clear understanding of regulations governing the protocol while others did not understand the term protocol and thought that they were being initiated onto a programme for detoxification.

Anastasia... *to me the methadone protocol just means, it's a new thing, it kind of brings it out to be less taboo than it was, you know what I mean? That's what it means to me.*

R *when you call it the course, I call it the methadone protocol have you heard that word?*

Tadgh *yeah eh no I haven't heard of it but... it wasn't a maintenance course that I came on to it was a detox I came on to.*

R *That's what you thought you came on to here?*

Tadgh *That's what I thought I came on to like.*

R *who told you it was a detox?*

Tadgh *The doctor actually said it was a detox...I felt I was duped in to it*

Despite being uninformed as to the full meaning of the MTP, the service users knew what rules were attributed to the protocol. Forty references from 18 sources described ***knowing the rules*** which they felt affected their treatment management in general practice. These rules applied to 1) ***urinalysis***, 2) ***attendance schedules*** 3) ***supervision of ingestion at the chemist*** and also how these rules could be circumvented 4) ***"working the system"***.

1) URINALYSIS

All of the service users were in favour of the necessity of urinalysis which implies a compliance with this aspect of the protocol. There were 99 references from 25 sources describing the process of urinalysis and what that entailed in practice.

Daithi *Yeah I come here and give me doctor a sample, yeah I mean there's no point in being on a methadone programme, if you don't give a sample.*

However how the urine was obtained caused variable responses. Three participants from the same surgery explained that the reception staff would request the urine sample.

R *On that, do you mind the receptionist asking you for urine?*

Kaitlin *No, no, it can be a bit you know like...? when you are asked to go to the bathroom. She'd always wrap it in tissue now like and I'd go in and I'd have it wrapped in tissue. Give it back to her and she'd just put a glove on, you know? it doesn't really bother me that much, but other people would be looking. I don't mind.*

There was considerable strength of feeling about the frequency of urinalysis. Most were in favour of random urinalysis which was supervised. Two service users had rarely if ever had supervision of urinalysis.

R *Are you saying that in all the time you've been here, five years, you've never been supervised in the loo?*

Darragh (80mls) *No.*

Helen (70 mls obtains extra benzodiazepines with another GP) *No, I never have had it. I've actually have had a supervised the whole time I've been here only once!*

R *Only once?*

H *Yeah the whole time once yeah the whole ...*

R *In six years?*

H *Yes!*

In the same practice a different story emerged.

Rosin (70mls obtains benzodiazepines) *Occasionally the doctor herself she'd spot supervise you.*

R *So you don't have any trouble with that?*

Rosin *It needs to be done.*

The practice of giving "bogey urines" was discussed at length and service users expressed anger about the lack of supervision.

Helen *He's (brother who attends the same surgery)going up now to actually get it he takes that every Friday and now he's getting it weekly and he takes that and he sells the whole lot of it and like he keeps that 80mls cause he has to be supervised drinking it...and he just gets a urine, gets the urine off someone every week, they don't supervise, but the thing about it is, its it's obvious, oh my god like, how do they not know this these people?... but the minute he done that eh he's not supervised he's back on the gear. So definitely there should be more supervised, like at least it's what do you call it, I think we should be supervised every week, I really.... every week!*

The following informant discussed the economic benefit of providing another service user with a "bogey" (false) urine.

R *And have you, have you been asked outside the door?*

Cormac *Yeah, I've been asked outside the door, I've been phoned to give urines, you know people have talked to me and told me about, they've made urines up, their child did urine into a bottle and then put a bit of valium in it and then put methadone ...it's funny that you say that like now like only last week I was actually asked to sell one of me urines to somebody like...'ill give you methadone... I'll fix you up with methadone if you give me urine to get me methadone, you know like?*

However actually providing a urine poses other problems.

Cormac *He cant urinate with someone watching him, right, so what he does is he*

gets... he's after using it to his benefit now, what he does is he fills a 5 ml barrel with clean urine, someone else's urine now, squirts it up behind his foreskin and then he'd say, oh right I'm ready to go! lets it go, there you go and just goes to the toilet ...will not get a bogey urine but he does it you know and that's you know it's disgusting to think of doing that like...you know what I'm saying with girls squirting it up them and letting it back out... someone else's urine.

ICGP (2008:23) Where possible the urine sample should be directly supervised. However in the primary care setting this may not always be possible for logistical reasons. In this situation all reasonable precautions should be taken to ensure integrity of the sample e.g. check temperature strip on the urine jar; no coats or bags allowed in the toilet; laboratory testing for methadone metabolites and creatinine.

2) ATTENDANCE SCHEDULES

Attendance which involves the ongoing monitoring and review of service users was reported as erratic. Some service users attended weekly, others two weekly and others 4-6 weekly regardless of methadone dosage.

Helen *Every month yeah Dr X though sometimes only makes it every 6 weeks...well other Dr she puts me on every four weeks every month she's a bit more careful, but Dr x is a.. a bit more easy going so like ...*

Niamh (150mls) *I come down for Methadone like I would only see him six times a year probably.*

R *And tell me this much if you only see him six times a year how many times do you get it from the chemist then?*

Niamh *Oh I go twice a week because me dose is so high.*

ICGP (2008:22) Once stable i.e. urine samples negative for opiates, a weekly review by the doctor is appropriate. Patients stable on methadone for a period of a year with urine samples free from illicit drugs may be seen fortnightly if it is considered clinically safe to do so.

3) SUPERVISION OF INGESTION

Six service users were not having any supervision of ingestion in the chemist despite methadone prescriptions as high as 90mls.

ICGP (2008:19) Once stable it is recommended that at least one dose per week is supervised in the chemist. Exceptions may be Stable patients on very low doses (e.g. <15mls) may not need supervision. Higher doses (>80mls) are potentially more dangerous if given in large take away doses. It may be prudent to have twice weekly supervision in such cases.

Daithi (60mls) *No I'm not on supervision, not at the moment.*

R *In the chemist?*

Daithi *No!*

R *So you take the bottle away?*

D *Yeah!*

R *You don't ever have to take it at all in front of the chemist?*

D *No, no cause I've built up that trust you know? If you give clean urines the doctor knows you are genuine after a while*

R *And when do you get your two weeks takeaway you were telling me are you supervised in the chemist?*

Padraig (90 mls and buys extra) *No!*

R *No so when you go into the chemist you could take... would you take one bottle away or would you take two bottles away?*

Padraig *I was at the start I just take the one away, Jesus if I took the two!*

R *So you can just go in and take your bottle you never have any supervised?*

Molly...*unless sometimes the doctor makes a mistake and he puts supervised on it because there is a supervised box and sometimes he forgets and just marks it yes but if they say to me you have to take it there, I have no problem taking it, once there is nobody in the chemist.*

Follow up telephone Interview with Molly – (This is a discussion in relation to the fact that Molly divulged that subsequent to our interview she now had to collect her methadone and have supervised consumption for the first time. I explained that I had not fed anything back to her GP and that I was ethically bound to protect her anonymity).

Molly this is not going to mess us all up is it? cause I couldn't take it if I had to collect it more than once –I never had to collect it in general practice before!

(It is unknown why this practice suddenly was changed 6 weeks post interviewing.)

Six of the service users were not supervised at all in the chemist and another had only recently been started on supervised consumption of their methadone. This facilitated the leakage of street methadone.

Follow up telephone interview Daithi on the subject of "buying extra" - its down to trust tightening the dose...every GP should take on patients, spread it out, its up to the doctors prescribing to take control, to monitor and he has to make a judgment, they are prescribing, tick daily supervisions, they have the final say!.

Bracketing Interview Final

R there is no point in having that guideline either its been made for a very good reason and there is very good research to suggest that patients should have their methadone supervised in the chemist, cause of the methadone deaths and methadone related deaths and letting methadone leakage out into the streets and the basic rule is that you tick the supervision box so the patient has to have a supervised dose in the chemist.

D) WORKING THE SYSTEM

Regardless of the fact that the supervisory details had been documented by the GP there were ways of circumventing the system. Twenty six references from 14 sources revealed different ways of "working the system". Olwyn described her way of working the system in detail in relation to the pharmacy.

Olwyn (prescribed 90mls- Takes 25 and sells the rest

O *Yeah, well no if I'm going anywhere now I tell the chemist. No! I need to take it in two doses because... I have things to do!...And that's what I do say to him, I've things to do today, so I'm going to take half me dose and your man's fine with it!.*

R *OK so you only take half in front of him and he gives you the rest to take away?*

O *Yeah I take it.*

R *But in fact that day you probably would not have to take it? You've got even extra so some Mondays you can get away with that can you?*

O *Eh yeah if I want to like if I want to I just ask for it, like can I take 40 mls now? I take 45 at the moment, I'll take 50 now and I'll take 45 when I go home or whatever you know what I mean? but eh some weeks I will just let him see me taking 95 just so that he doesn't be...*

R *The status quo?*

O *Yeah that's it! That's it exactly!*

R *And he lets you do that? surely he knows what you're doing then?*

O *Yeah well that's what he thinks that I'm doing! you know what I mean?...but I just tell him that cause I do say to him look it...that 95 mls affects me because it affects me eye-that's why I go all funny...so I can't take it all together so eh he kinda has to go with me like, its years of being in the system!.*

Working the system involved by-passing the guidelines for supervisory practices. This is in turn further influenced by the role of the pharmacist and communication between professionals.

Final Bracketing Interview

R I'm ethically and morally bound to expose this and I will be exposing the lack of adherence to guidelines...and in that chain of events it wasn't just the GP, it was definitely the chemist who was at fault and giving divided doses of methadone and that wasn't the only incidence, there were several situations where patients were not having supervision in the chemist and I couldn't have predicted this was happening.I couldn't have any bias because I didn't even know this was happening.I presumed that everybody was ticking supervision.

ICGP2008:19 The pharmacist is a very valuable member of the care team. Regular communication with the patients' pharmacist may often have a useful insight into patient progress by virtue of the fact that they are seeing the patient every day.

5.3.4 UNDERSTANDING WHAT INFLUENCES THE IMPLEMENTATION OF THE MTP

The MTP was initiated to provide a response to heroin misuse however service users described the structure of the scheme as it affected them. This structure was perceived to both effect and benefit others such a) ***drug misusers*** b) ***general practitioners*** and c) ***pharmacists***.

A) INFLUENCE OF OTHER DRUG MISUSERS

The influence of other drug misusers featured prominently in discussions when exploring the issues of maintenance. There were 35 references from 11 sources highlighting the responsibilities and pressures exerted on service users "to look after" other drug misusers. Attracta described how she looked after her brother giving him her methadone.

Attracta (80 mls+ buys extra benzodiazepines... *I was on heroin for about six months every Sunday, just to help me brother out for a sup of phy, cause he always done a double dose!*

R *So you had your methadone and then you'd not have it on the Sunday?*

Attracta *Sunday and I'd have heroin!.*

R... *give him some methadone is it and you'd have the heroin yeah?*

A...*only once every week, skin pop on a Sunday, every Sunday!*

Other ways of carrying out reciprocal care were revealed as follows:

R *Do you feel obliged to give somebody else your urine?*

Cormac *ehm...some people I would because when I when I was probably using I would've been with them and they probably would've looken after me in other ways, you know? and you know I'd be sick and they'd say right! I'll give you a squirt; do you know what I mean? Just to get you sorted!*

Olwyn *if it was some mad junkie came over and said, give us a urine, I'd tell him to fuck off! but if it was well, some people slip up all the time and they'd be afraid of their lives going into the doctor with a dirty urine, it's like everything it's like they are holding life and death over you, you know that way?*

Olwyn who described earlier her way of working the system also recounted how she had many people to "sort out" with her supply of methadone.

Olwyn... *he (friend) needs it 'cause he's going to be sick so I don't want to be leaving him so it's usually getting him to meet me somewhere with his car like...*

R *Your brother has already met you? (For extra methadone).*

Olwyn *He's already met me yeah halfway somewhere...*

Two service users explained that they could respond with authority to the pressure exerted to provide either extra tablets or clean urine for "bogey" purposes.

R *So do you feel that you should look after other drug misusers?*

Niamh *Would in me nuts, nobody looks after me when I'm strung out!... if you want to jeopardize your recovery for somebody else that doesn't give a shit about you, you go ahead and do it, but don't come crying to me!.*

Others such as Seamas who would have a clear identity as a criminal can be put under different pressures.

Seamas *....every gangster in the area knows me and knows me as an OK fella, anti police, anti things like that, ... they'd be friends all my life that have done favours, done things for me, I couldn't really say no if you know what I mean?, well I could say no, but I'd be opening meself to intimidation and all sorts then you know what I mean? I'd end up fighting with me own people ...I grew up with, you can't turn your back on everything, some people say you can, you have to make new friends but I'm forty years of age now, it's not friends it's a way of life, it's not some fella's got to make new friends these people I've known since I'm a young fella and what do they say? Birds of a feather flock together?*

B) WHAT INFLUENCES GENERAL PRACTITIONERS?

Exploring what service users felt influenced the GP there were 66 references from 23 sources all of whom had an opinion on what influences GPs to register methadone patients.

R *Would it influence the GP if money was involved to take on methadone patients?*

Molly *Oh I don't know! Yeah, yeah, I don't think my doctor it wouldn't. He gives me the feeling that he wouldn't, every treatment should be available for everybody, that's the feeling he gives me, professional?*

One service user who is very happy with his "methadone doctor" is registered with another GP who recently has been signing on methadone patients. He described the situation:

Daithi... *he (own GP) has now started taking them on and each time I go into his practice to see if I'm sick he's always pestering me, oh I'll take you on, I'm your family GP, you should be coming to me, and all this...But I know, I remember Dr X telling me he could make a lot of money out of it and he said the more patients you take on. I'm telling you he's (own GP) trying to poach me, when I go to see him I've told him look! I'm happy with my doctor (who prescribes methadone).He doesn't give a shit about me to do that! To get me on his books so he can get money from the eastern health board and I know that!*

Others had a pragmatic response.

Olwyn *I think maybe, maybe someone, maybe someone might go in there that has a story that whatever might hit a nerve and it might make them think, shit like well maybe I should be doing something, like I have the power to do something whatever.*

Seamas who identified himself as a "lifer" displayed an ownership of the maintenance system and identified that his doctor recognized his professional responsibility to their community which he describes as follows:

R *What do you think influences your GP?*

Seamas *Well him himself, I think he ...it's not just a flimsy overnight thing he just decided to give methadone, he has. he's prescribing it so long now and looking at the position the people are in now to what they were before he gave it to them, he's put a lot of thought into it, it's not just a sideline gimmick going on down here! ...completely serious you know and we would have seen people now ... when I say we, me the doctor and everyone else that's in the place...we would've seen people coming in here about eight years ago swallowing bullets and being chased all around the country by police in an awful condition, coming in all cleaned up and looking well and they'd be going off to work.*

C) THE INFLUENCE OF THE CHEMIST

The influence of the chemist or pharmacist was described in-depth. There were 100 references from all 25 sources commenting on pharmacy services and relationships within the chemist with both pharmacists and staff. Influencing factors such as financial gain were discussed as follows:

Saoirse *...like the chemist for every patient ..., yeah I think I'm not a hundred per cent sure but I think it was €100 for every patient for probably a month or you know which some chemists could have like up to probably a hundred to three hundred patients which is an awful lot of money.*

Negative attitudes of staff members to methadone clients were revealed:

Ken *The only thing, this talk about GPs, the only thing I would change is the chemist...go into a chemist right and like, say I'm the first customer in there, I'm sitting there and say four people come in and I'm sitting there for around say fifteen twenty minutes because there's people coming in and out and the chemist they treat you like a second class citizen. It's like, I know like it's, how can I say this, it's like being back in America in the sixties when there were the blacks and the whites, that's exactly ... you're classed as a second class citizen, you know what I mean... and it's horrible, do*

you know what I mean, you're just sitting there... and in the end of the day like I do... like they are getting paid big time for us, you know what I mean?

Issues such as privacy as well as waiting to be dispensed methadone were addressed frequently:

Niamh *it's a fucking kip!...you go into the chemist and if you walk into that chemist and there's nobody there and you hand your prescription over, you're first in that chemist, if six thousand people walk into that chemist behind you looking for prescriptions that aren't methadone you will be put to the back!*

R *is there a place in the chemist that you can have it privately take your methadone?*

Niamh *no no a little fuckin a little pole and you walk behind the pole... but everybody knows what you're doing when you walk behind it.*

However there were some good aspects to pharmacy encounters as four participants stated that they had been moved from difficult situations at their own request to more suitable chemists. This shows an ability to negotiate a change of pharmacist similar to the ability to negotiate a change of GP.

Sean *...but the one I go to now...he treats me with the upmost respect like every Christmas he gives me a Christmas present, do you know what I mean? The girls that work there as soon as I walk in every Tuesday morning it's... How are ye Sean? Are ye alright Sean?*

Service users described how they influenced the pharmacist.

Erica *But I would still like to cut down to a lower dose. Like I went into the chemist right and I said to the chemist, which I shouldn't have been doing cause I said give us 40 mls!, I don't want 80 but give me 40 and right I was delighted!.*

R *And the chemist did that even though the prescription said 80?*

Erica *Right!*

Final Bracketing Interview

R ...the really annoying thing was that the patients were being prescribed huge amounts of Methadone and only taking a quarter of it in terms of, you know, the fear that patient would withdraw and also would overdose you know so I felt I had to say to that patient afterwards, look, you know you really are dealing with a lethal dose here if you reduce that much?.

The frustrations of the researcher are also echoed in the previous study where informants considered the importance of having confidence in dealing with deception. This took time and experience to achieve.

Masters study Informant 1...if people are not being truthful I will let them know...there is no point in letting them think that they're getting one over on you ...so you have your antennas out all the time.

SUMMARY

This third theme was developed from the meaning statements where service users described their understanding of the Methadone Treatment Protocol. Meaning units developed were: ***why the protocol was necessary- what the protocol means to the service user- and understanding what influences the implementation of the MTP-*** These findings will be discussed further in Chapter 6.

5.4 THEME 4

THE EXPERIENCE OF ADDICTION AND IT'S EFFECT ON FAMILIES

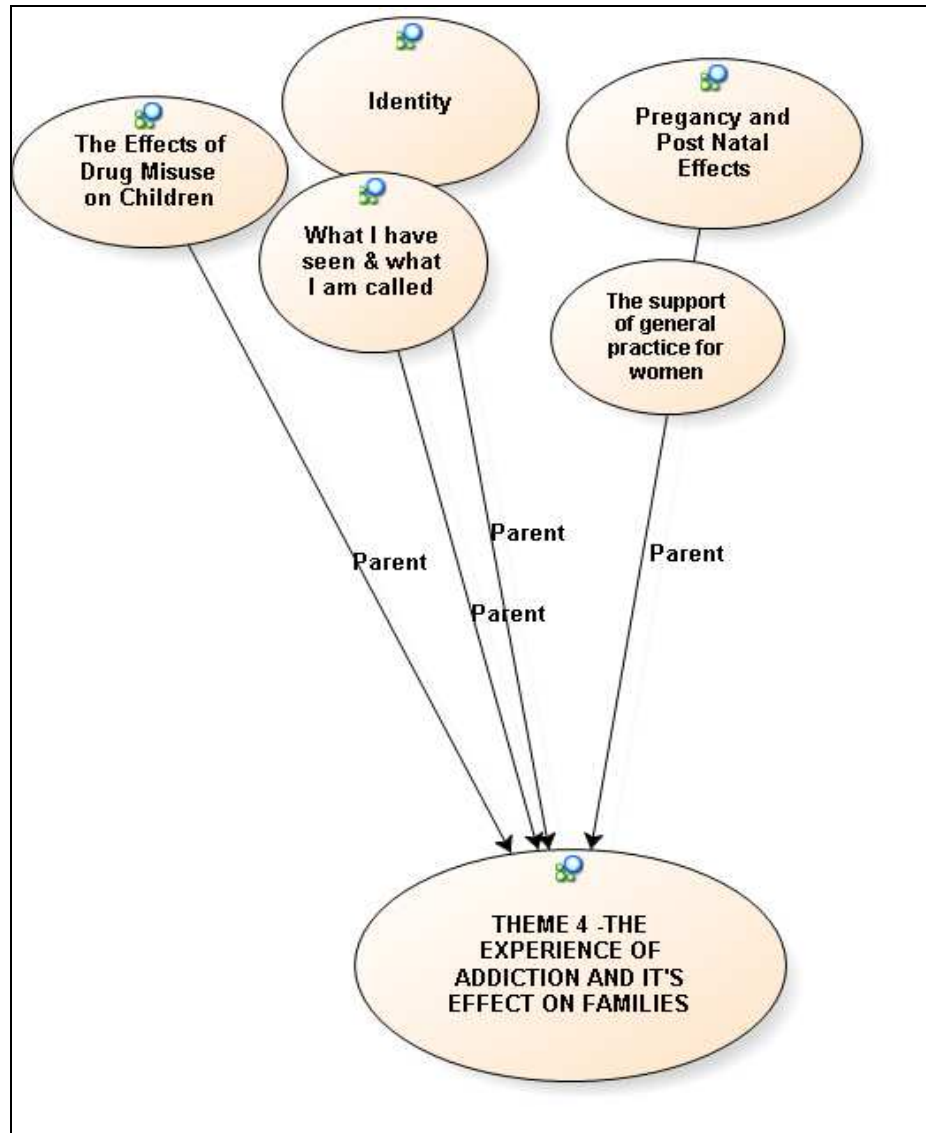


Figure 4 The Experience of Addiction and Its Effect on Families. (NVivo Model)

5.4.1 THE EXPERIENCE OF ADDICTION AND IT'S EFFECT ON FAMILIES

This theme was derived from the developed themes in which the service users described their individual experiences of addiction and the effect it had on their families. Throughout the interviews the essence of the lived experience of addiction was evident. Expressed were descriptions of identity as opposed to the self descriptors associated with the dosage of methadone consumed, identified in Theme 1. Also evident in the descriptions were scenes of family life which involved the effects of drug misuse on children and how family is both valued and seen as a significant issue in both recovery and relapse. Meaning units were described as: ***identity, pregnancy and post-natal effects on the mother and baby and the support of general practice for women.*** As the study is oriented to the experiences related to general practice the meaning units which were not directly related to this experience have been omitted in the results. These experiences are important as it is the responsibility of the family practitioner to provide care for families.

5.4.2 IDENTITY

The perceptions service users hold about their identity as a drug misuser receiving methadone sheds light on how that identity is constructed by the environment in which they live. There were 80 references from 24 sources exploring the feelings attributed to the stigma associated with being an "addict", a "junkie" or an "ex addict". These feelings were expressed as ***what I am called*** and ***what I have seen.***

a) WHAT I AM CALLED

Six service users expressed a wish not to be called "junkie" while 16 referred to themselves or others as "addicts".

Niamh *I don't know but a lot of people would be ignorant toward the whole drug thing in their eyes maybe I'm a "junkie", in my eyes I'm an "addict"!*

R *or an ex-addict?*

N *no, I'm an addict*

R *Addicted to what though?*

N *I'd say I would be addicted to methadone now right but I am just an addict and I have an addictive personality like... I smoke like heroin you know what I mean like? I would just say, I'm an addict and I have an addictive personality, so I can't kind of get sucked up in all that drug thing again because of the addictive personality, it's going to lead to death.*

Feelings were expressed in relation to attitudes of doctors in the treatment clinic and how that impacted on issues of identity.

Sean *You feel subservient yeah as if the health board are trying to keep you that way but in a way ...but even people that work in certain places even say the same thing about (doctor in clinic) she thinks she's just up here and we're all down here like with the attitude she has towards addicts especially, that's why I can't understand why she is working with addicts doing all this like when she this awful god complex about her just because she is a doctor.*

The following extract identified that stigma and marginalization are features of the difficulties that drug misusers encounter regularly- this extract features the attitudinal stance of nurses:

Attracta... *yeah there's always one, you'll get one I'd say out of six nurses that has it for drug addicts, they just think you're a needle user, well everybody does when you say you're on methadone!*

R *Everyone?*

A *Everyone insinuates oh God, Jesus she's stuck needles in herself and that's it!*

Two service users expressed other aspects of identity which were defined by past criminal activities.

Seamas... *no and I am what I am in the community...I was like a band of thieves and*

we had an old fella Fagan and all and my father Lord rest him, he was a thief was an armed robber himself! Himself and me mother tried her best but she wasn't there all the time you know? She worked and stuff so we were ehm I won't go as far as saying we didn't know any better you know, like twenty years ago, the recession in the country and things was different.

Cormac... *that's probably you know, the dealers in the area would know that I'm not buying so like obviously I'm doing all right you know?*

R *So now you'd be a target for people?*

C... *yeah they'd be trying to pull me back in or get me selling one or the other like you know he's clean get him ...!*

Identity and stigma were interwoven concepts throughout the interview dialogues and the new or transformed identity of attending a GP was considered an advantage.

Saoirse *Like they're very respectful and you know you're not treated ehm any different from any other patient.*

Assistant Researcher *So the whole thing about being treated the same like kind of, you've acknowledged that you have tried to move away from that to be treated with some ...not looked down on that's very important?*

Anastasia *yeah that is important.*

AR *and you get that here?*

A *You do you definitely get that here... I'm treated the way other patients are treated yeah.*

Bracketing Interview 5

R we're back to the fact, and part of the whole experience is that patient's moved from one identity to another. The identity of being a "chaotic drug" addict in a treatment clinic, to the identity of somehow progressing and transforming that identity into one that now is a "normal" identity and a "stable" identity which is attributed to Methadone and general practice.

B) WHAT I HAVE SEEN

Identity was also described within the descriptions of the social environment that service users found themselves immersed in. There were 34 references from 13 sources describing the experience of death both as a result of drug overdose and suicide. This was described as ***what I have seen.***

Erica *And though I ended up in hospital that time, me mother died, me sister killed herself I got a load of money, I had a car I just went on a fuckin mad one and I just ended up giving meself a And I found my groin!*

Ken *I was only twelve when I seen me first OD, I seems a bloke going blue to white to grey... I was only twelve and like that's not nice for a kid to see.*

Robert *... there with a big branch sticking out I think they've taken it down now and he hung himself there, and he had his methadone in his pocket and his tablets in his other pocket you know what I mean? yeah I seem to be cursed I am, sometimes I feel cursed or something... yeah like if its someone close or someone that you know too, you're like Jesus Christ anywhere I go someone croaks it or something.*

The effect of drug misuse on families was described by numerous participants:

Cormac *... and there used to be another chap whose brother died of an overdose in the meantime, he only died two months ago like from an overdose a drug overdose you know... his father hung himself over them going on drugs like he was dead and his family is from (locality)who were all big drug dealers.*

Kaitlin *My boyfriend died and it's just ...*

R *I'm very sorry was that through drugs?*

K *... it was actually mm it said in the Coroner's report that there were excessive amounts of methadone in his system.*

R *... and were you told the cause of death was excessive methadone?*

Kaitlin *That's what they had down on the report yeah ...nobody ever discussed with me about it; they only discussed it with his mother. I still don't know to this day was it methadone, you know he was my long term boyfriend.*

Field Note Re Kaitlin

She said her own mother had died 6 weeks ago – I wondered and asked her if it was alright to continue – she said she had told the nurse and it was ok- she wanted to do it ... the coroners report showed an excessive amount of methadone in her boyfriend's system- no other drugs. She had been given no explanation.

These excerpts highlight the world of drug addiction which the service user is exposed to on a regular basis. No service user expressed that they had received counselling in general practice in relation to these events.

Final Bracketing Interview

R I've learnt so much about methadone deaths, you hear so much about it you almost become inured to it until you see somebody in front of you saying you know he died from a methadone overdose.

5.4.3 PREGNANCY AND POST-NATAL EFFECTS ON THE MOTHER AND BABY

Service users described how they attended the GP surgery with their children. Nineteen service users had children (37 children Appendix 7 Table 3). Twelve service users (n=10 Female, n=2 men) utilised general practice for their children's' needs as well as their methadone prescription while 19 of the sample had children. Describing their treatment while pregnant or in the post-natal period, the benefits of general practice were described in comparison to the treatment received in both treatment clinics and hospitals. Maintenance prescribing is the core treatment for managing pregnant women dependent on heroin. Those on methadone in pregnancy are noted as a special group which can be looked after by a Level 2 GP using a shared

care ante-natal model.

Ten women and 1 male participant described their experience of pregnancy while they or their partner were taking illicit opiates and or methadone. These responses were divided into a) **professional attitudes** b) **neonatal effects** and c) **post-natal difficulties**.

ICGP (2008:27) Attracting and maintaining women in treatment is important and should always be prioritized.

A) PROFESSIONAL ATTITUDES

Most of the discussion revealed that the service users focused on negative professional attitudes in maternity services both in relation to pregnancy and the use of methadone.

Molly *Going in and giving your details, everything's OK and as soon as you say you're on methadone they would change, how could you do that to a baby?*

R *And do you feel that you could have one now?*

Molly *I wouldn't have one now, it's too late now, I'm thirty-six now and I thought I'd be well off the methadone by now yes.*

R *So what you're saying is that you have two concerns about being on methadone the effect on a baby and the other thing would be how people treat you. People that you are talking about, am I right, would be people like me? doctors? what about other people?*

Molly. *Well not really cause in the way that they treat you different, like... mm I just won't have another child!*

The following extract highlights the feelings expressed when Attracta who had been cared for during her pregnancy in general practice went in to the maternity hospital:

Attracta.*It's like you get a gown thrown at you the minute you hit the door, little holy angels it's called when something's wrong with your baby, if it's a baby addict I think!(Tearful).*

Masters Research (Informant 8)

I worked in a hospital for a long time...I mean they were treated like lepers, you know, we were gowned and masked.

Rosin, who was also cared for in general practice throughout her pregnancy, expressed her feelings about how her care was managed post-natally in the hospital.

Rosin *Now I wanted to breastfeed me baby because he was so small right and the nurses made that virtually impossible!*

R *Why?*

Rosin *They ran me around the hospital like a blue arsed fly saying, there's a breast pump downstairs! No there's a breast pump upstairs! No it's downstairs! go up to the first floor and they'll give you one, up to the first floor, oh I'm telling you now it's downstairs...he missed out on the colostrum right? he ended up... he did get an odd bit of breast milk here and there but it just messed the whole thing up on me. A doctor called x came up to me and tried to talk me out of breast feeding the baby saying that I was HCV positive OK? and that I shouldn't be breast feeding the baby, that if I had a cut on me nipple that basically the baby has a fair chance of getting it ...but I was sent back up again and then a nurse sat in with me, spoke to me and she more or less gave me her opinion and I could hear the judgmentalism coming across and I told her well, look, even monsters love their babies! and if that's what you think I am, I still love me baby regardless OK?*

Two participants spoke positively of liaison midwives.

R *Did you meet a liaison midwife?*

Niamh *Yeah aw she was great she was very good very ordinary... very open and I didn't feel mistreated, I didn't feel that...*

Linking up services from primary care to the maternity hospital is the remit of general practice as outlined in the guidelines as follows:

ICGP (2008:27) *Liaison midwives appointed by the HSE, work in the three Dublin maternity hospitals. Their role is to provide a link between drug treatment services.*

However professional attitudes were also negative as Erica described her past experiences when she asked if she could commence methadone while pregnant.

Erica *Now I waited until seven months thinking I could get on the methadone... Now I wanted some guidance from the clinic... do you understand?*

R *What's the right regulating dose?*

E *Yes because if... I didn't understand what's the best thing I could do for my baby and ehm now I was taking methadone and I stopped using MSTs at night but I wanted their guidance and your woman said we can't give you methadone on your last ... (Trimester)... I went onto the Temgesics myself. Somebody else told me who was a drug misuser- they're not addictive cause they're not as strong, go on to them!*

This extract highlights a missed opportunity of engagement at the time of pregnancy.

B) NEONATAL EFFECTS

Seven participants discussed neonatal withdrawal symptoms with two stating that phenobarbitone was required for their babies.

Erica *...they didn't recognize it though. She was a little twitchy, you could just see a little twitch in her eyes, you know but she did cry out and she fed OK... Now a fella came in..... All my eh, withdrawals left me through birth when I gave birth. I came out of it and I had no withdrawals, it was grand.*

R *Did she have any withdrawal?*

Attracta *She had jaundice, no and I was looking at her I kept saying what am I waiting on her to do like?...yeah I did the legs!*

R *...The legs, they twitched?*

A *...twitched, the knees and all just goes up and down and it broke me heart, cause the poor little thing I felt so sorry for her!*

Helen *Oh I'll never forget it, yeah and like all through the child had a problem taking her bottles and she just kept getting sick!*

Field Note Text message from Helen (post interview)

Thanks for the gift voucher but there was really no need. I found it therapeutic to talk even though it brought back painful memories I'd rather forget of my child being in hospital for 126 days.

Four participants admitted taking heroin at the time of pregnancy.

Niamh *I ended up using when I was pregnant!*

R *Did you?*

N *I used when I was pregnant (whispers) it was like you can't do that and I was like yes! I fucking can! I want to do it!*

Sean *she found out she was pregnant she was after using that morning I went straight out then and I got I bought a bottle of methadone on the street ...and I regulated the dose so that she would be ok she wouldn't feel any withdrawals but at the same time she wouldn't be stoned do you know what I mean?*

C) POST-NATAL DIFFICULTIES

Five participants recounted post-natal difficulties and described how they reacted, with 3 increasing their methadone dosage and 2 taking illicit drugs.

R *Did you go back on anything then?*

Erica *Somebody came in and brought me in Temgesics and I went to the toilet and I banged them up, I found one of them CIN bins got works out of it went to the toilet banged them up came out and breast fed her.*

Helen was cared for in general practice and recounted her experience of requiring extra methadone.

R *and did you feel like getting any extra methadone then or any extra drugs*

Helen *...like that's the thing like when I came actually home from the hospital I went straight to doctor and and I got straight back up to to 40 I got 60 mls and then up to 80, I didn't want to stay up to 80 like*

R *Why did you think you needed extra then?*

H *The strain I just needed something to calm me down and what do you call it get me through this... I and seeing me baby like that ...*

Saoirse opted to have ante-natal care in the hospital but attended her GP weekly also for methadone maintenance. Post-natal relapses were revealed:

Saoirse... *was down to 20 mls and I relapsed. It wasn't relapsed on heroin it was on methadone. After I had a, I had a baby seventeen months ago and he was in intensive care for six weeks and with the other four kids, it's no excuse like you know but I was up and down from the (Maternity hospital) three times a day and then back to school and I just started taking an extra sup of methadone for the energy like and but it built up and it built up and it built up like, you know where I was on 20 mls then I got back up to 80 mls which was an awful lot for me cause I wasn't used to taking that amount that was a big jump like but I'm coming back down like slowly now so ...I think it was to meself as well the doctor, like I didn't want to admit kind of that I needed more you know what I mean cause I was doing so well you know(Saoirse renegotiated with her GP and her methadone dose was increased).*

Rosin *I was down I think to 30 mls at the time and I had to go back up to 80 mls cause the baby was taken and I was hoping to cut down more*

R *How soon then after that did you feel that you needed the gear again?*

Niamh *The week after she was born I had a slump it was like I deserved it!*

5.4.4 THE SUPPORT OF GENERAL PRACTICE FOR WOMEN

Three service users described the support they received in general practice both during pregnancy and post-natal care. All three were cared for under a shared care model.

R *But who looked after you during your pregnancy when you were on the methadone?*

Attracta *Oh here yeah I came here of course!*

Helen *Dr X has always been my GP...since I had my first child...I saw that nurse when I was pregnant ... actually (doctor) was here she was with me when I was pregnant through me pregnancy.*

R ... and during your pregnancy your doctor looked after you here as well?

Rosin *Oh yeah!*

R *And she changed the methadone dosage?*

R *yeah!*

Rosin... *eh I had that (coil) done two or three weeks ago.*

R *Great and the nurse or the doctor did it for you?*

Rosin *Both.*

All expressed confidence in their GP and described continuity of care. A follow up telephone interview with Helen revealed that she felt she had possible post-natal depression (the baby was then 7 months old) but was being monitored by her GP.

Follow up Telephone Interview ...*you basically captured everything(in the interview) - doctor is very helpful - very caring –she has put me on a watch, monitoring me - all the services are there...*

SUMMARY

This theme was derived from the developed themes in which the participants described their own experiences of addiction and it's effect on their families. Meaning units were described as: **identity, pregnancy and post-natal effects on the mother and baby and the support of general practice for women.** This theme explored the meaning of addiction and how that impacted on service users home lives and shed light on where general practice fitted in within the context of family. These issues will be discussed further in chapter 6.

CHAPTER 6: DISCUSSION OF THE FINDINGS

6. 1 INTRODUCTION

This chapter discusses the findings in relation to the general body of knowledge, reflecting on the original literature review, the objectives of the study and the outcomes of the analysis. Prior to this phenomenological study there was a scarcity of literature pertaining to service users' views of methadone treatment in general practice in Ireland. These views and experiences are an important resource in the substitute prescribing process (Neale 1999) and give insight into the professional intervention of service providers in the lives of service users. Considering the perspective of these service users in the context of current practice, the aim of the study was to explore how the MTP was being implemented in general practice. The objectives of the study were to describe the users' lived experience of treatment and their experiences of being involved in decision making and management of their treatment. The findings enable us to discern both the benefits and shortcomings of methadone treatment in General Practice in Dublin and identify what steps may be required in addressing any limitations or deficiencies in treatment.

6.2 THE LIVED EXPERIENCE OF THE MTP IN GENERAL PRACTICE

The essence of the lived experience of receiving methadone treatment was described in a myriad of ways which reflected the multiple complex interplays between what the service users had experienced as a result of their personal history of drug addiction and what they now depicted as their experience of treatment in general practice.

Describing their past experiences of addiction most of the service users expressed their views in terms of *what I am called* and *what I have seen* as if these experiences together were connected to their current identity. The stigma of *what I am called* was described as one which was embedded in a past identity of “junkie”, whereas now those who were registered on the MTP viewed themselves currently as an “addict” or ex “addict”. “Junkie” was seen as an unacceptable identity. This transformation seems to have occurred due to the decision to opt for methadone treatment which was viewed as more acceptable in the inner city community of Dublin than being categorized as a “junkie”. The concepts of this past identity or what researchers have labeled as a ‘spoiled identity’ were laid bare as service users spoke retrospectively of their drug misuse and described the environment they lived in. Issues such as these are often not voiced or heard (Etherington 2008). McIntosh & McKeganey (2001:51) speak of the central feature of a spoiled identity as being the realization by an individual that he or she exhibits characteristics that ‘are unacceptable both to themselves and significant others’. This invokes the concept of stigma which although felt acutely by the service user, gets little attention. It is clear from the findings that consuming methadone provides a differentiating social identity. These findings have resonance with an ethnographical study carried out among an opiate consumer community in Barcelona (Spain) from 1994 until 2000 which analyzed the meanings that consumers build and handle around the substances that they consume (Albertín & Íñiguez 2008). Their approach emphasized the consumers’ understanding of drugs and the type of relationships they maintain between themselves and their social environment. Those taking heroin were recognized as active members of the group of consumers while those who took methadone were considered former ‘mates’ who had opted for methadone treatment. The findings of the current study describe a new identity which has been constructed not only by entering

a treatment environment and leaving the addicted lifestyle but also as a result of taking methadone. Methadone identities were described further and self definers such as "lifer", "maintainer" and "reducer" evolved and were developed. "Lifers" appeared to choose to remain on maintenance, "maintainers" identified themselves as happy with current treatment although many topped up their methadone or bought extra. "Reducers" were enabled to have a treatment plan over which they had control. The community environment where treatment was situated constituted a significant deterrent for both lifers and maintainers to change to a more transformed identity. Those who were reducing their dose of methadone did not report being involved in diversion and as is consistent with the established literature on recovery (McIntosh & McKeganey 2000a, 2000b, 2001) appeared to be managing to construct a life outside that of drug addiction and were developing strategies which did not seem to pose a threat to their new status. These self definers or descriptors signaled a new identity which was reconstructed subsequent to the service users' existence as a heroin addict. This process of change communicated a transformation to a new and in most cases preferred identity of methadone user.

The concept of treatment identities constructed by the substance of methadone has been discussed in the literature review (Fraser & Valentine 2008). The data prompt further consideration of how service users constitute their experience of methadone and what social roles this treatment creates. This has more than descriptive power and attention needs to be paid to the formation of these new identities. This challenges service providers in general practice to become cognizant of how service users view themselves and the identity that is created by not only the dosage of methadone that is prescribed but also how that translates into practice and the controlling aspects of treatment .

The concepts of stigma and identity were further constructed by the experiences associated with the past environment of drug misuse –

what I have seen. The trauma of suicide, drug related deaths, sexual abuse and violence in the home was an integral part of the stories expressed in the interviews. These descriptions of multiple deprivations associated with drug misuse which synergistically exacerbate one another have also been described in Dublin by Saris (2008:11). He postulates in most respects that these are impervious to easy solutions. What each service user had in common was a desire to rebuild this aspect of their identity and their future.

General practice is a place where these issues could potentially be discussed and receiving treatment in general practice rather than a treatment clinic was viewed by service users as both transformative and beneficial. Similar to the study by Lawless and Cox (2003) a key advantage of GP involvement in MMT was seen as a reduction in stigma. There were several other beneficial aspects identified in relation to this treatment environment, described as *a place to be treated as an individual, a place to get clean, a place which is confidential, a place to reduce, a place to develop relationships and a place to sort things out.*

As identified previously in the literature, general practice in Dublin had a history of being involved with drug misusers prior to the introduction of the MTP (O'Kelly *et al* 1986, 1988, 1996) although GPs initially began methadone maintenance prescribing because of the problem in their practice, rather than a special interest in drug addiction (Langton *et al* 2000). Historically the response was reactive rather than one of planned care. Nevertheless service users in this study spoke positively of the current treatment environment. This 'place' was different and distinct and a place where the overall experience of care was valued in comparison to past experiences in treatment clinics.

These descriptions were meaningful in the lived experience of service users as the clinical environment of general practice was defined as *a place to be treated as an individual.* There are several pragmatic

reasons for valuing individuality. Many of the informants had children (76% Appendix 7 Table 3) and most described care which was carried out by the same GP who prescribed their methadone. The reality of attending weekly, having designated appointment times “just like every other patient”, having problems sorted out at this time and being afforded the opportunity to normalize their lives was described as distinctly related to the setting of general practice. Those that attended frequently other than at their designated time for methadone, attended with their children.

Clinical guidelines on drug misuse and dependence in the UK stress that when providing appropriate care for drug misusers the clinician should focus on the patient themselves but also take into consideration the impact of their drug misuse on other individuals—especially dependent children—and on communities (DoH England 2007). It is known that Illegal drug misuse tends to cluster within families (Forsyth 2003) and children who have been exposed to opiates in combination with additional drugs can have a high risk of delayed development and behavioural disorders (Sandtorv *et al* 2009). Service users recounted their experiences as mothers and fathers and their accounts provide an insight into the lives of families affected by drug misuse. Prior to this research the vulnerability of female drug misusers and their babies during pregnancy and immediately post partum had been relatively ignored in the Irish literature, although female drug misusers and their children have been identified in Ireland as having particular needs that require careful consideration in service planning and provision (Farrell *et al* 2001). The numbers of females in treatment are increasing in Dublin and the ratio of male to female opiate users is estimated as 3:1 (Comiskey 1998) with 28% of female drug misusers who present for treatment living with another drug misuser compared with 18% of men (Moran *et al* 1997). *The support of general practice for women* was evidenced by the stories told by the women (14) who described

services they received both for their children, and themselves. Women described support in addition to methadone treatment as specific to womens' health issues such as ante-natal care; post-natal care; cervical screening; weight reduction information; investigations of infertility; and provision of medical care for childhood illness. Effective treatment of the parent can have major benefits for the child. Frequently high levels of unmet service needs have been reported among drug misusing women, particularly for legal, housing, medical and employment assistance (EMCDDA 2009, Smith & Marsh 2002). The data suggest that the GPs in this study were providing gender specific services for female service users and thus fulfilling an important service need for this cohort.

However, as was evidenced in this and the foundational study (Latham 2003), stigma and marginalization was experienced from professionals both in ante and post-natal care within the maternity services. It is recommended that women on MMT are encouraged to breastfeed (Jansson *et al* 2008) and two of the women in this study did, although one who was HCV+ was actively discouraged in the maternity hospital regardless of the fact that she herself was aware that the risk of transmission during breastfeeding is low (Polywka *et al* 1999). A recent National survey of neonatal units in Ireland and the UK supports this finding as it identified that mothers on methadone whose serology was positive for hepatitis B and/or C were four times more likely to be discouraged from breast feeding (O'Grady *et al* 2009).

It has been recommended that better treatment for drug misusing women should involve the whole healthcare team from receptionist to doctor and that assessment, triage, case coordination and referral services should be provided in a supportive, culturally sensitive, and non-judgmental environment (Winklbaaur *et al* 2008). This was not evident in these findings. Recounting their experiences of pregnancy and the post-partum period, service users discussed their fears surrounding their babies potential withdrawal and their own difficulties at

that time. From the concerns expressed it was clear that specialist services had failed to assume full responsibility for their clients and that service provision was not individually tailored in the maternity hospitals, although two service users spoke positively about liaison midwives.

Toner *et al* (2008) when exploring the views of professionals and service users with regard to maternity drugs service provision in Bristol, UK, found that effective multi-agency and multidisciplinary working; early engagement; a service-user centred approach; positive and non-judgmental staff attitudes contribute to good maternal and child outcomes. Consistency and clarity within and across complex services, and continuous service development were identified as necessary to effectively meet the needs of an extremely vulnerable population. This was not evident from the reports of service users in this study. In the short and longer term international literature relates that mother and child do best if multi-disciplinary treatment is initiated as soon as possible in pregnancy, maintenance prescribing is permitted, and there is regular monitoring (Winklbaaur *et al* 2008). The potential effect of maternal methadone dose is very important (Lainwala *et al* 2005) and infants of women included in substitution treatment programmes have been shown to be at high risk compared to infants of women without such an addiction. Level Two GP's skilled in combined care services were caring for these women in general practice and had the ability to maintain this specialist service within the treatment environment of general practice (ICGP2008)-(At present Level One GPs are encouraged to refer pregnant drug misusers to liaison midwives and specialist services). This is a significant issue for general practice as the use of opiates by pregnant women may result not only in a withdrawal syndrome in their newborn infants but also disruption of the mother-infant relationship, sleeping and feeding difficulties, weight loss and seizures. Coghlan *et al* (1999) have described the baby with neonatal abstinence syndrome as the 'most vulnerable victims of drug misuse'.

They carried out a twelve month review of infants admitted with neonatal abstinence syndrome to a Dublin neonatal intensive care unit. The study revealed that the duration of withdrawal symptoms is loosely related to drug type, but an increasing duration of symptoms was noted for infants exposed to benzodiazepines. As documented in the review of the literature this is also a significant issue in practice and the findings also reflect a prevalence of benzodiazepine misuse which is particularly prevalent in Irish females (NACD DAIRU 2008). Problems with parenthood and managing these mothers and babies can be challenging for the GP in the inner city (Latham 2009). Six of the women in the study reported that they did not use benzodiazepines, five were prescribed benzodiazepines and bought extra as well and three reported that they just bought their own supply. This finding is not unexpected as Quigley (*et al* 2006) identified a pattern of higher diazepam prescribing in areas of greatest deprivation, where prescription sedatives play a complex role within troubled families. Female patients living in the most-deprived areas were found to be more likely to receive diazepam than those living in the least-deprived areas and the neighbourhoods where GMS benzodiazepine prescribing was highest tended to have the highest rates of treatment for opiate addiction.

Considering the views expressed by these female service users it seems essential that women are provided with continuing support both while in general practice and also when they transfer to maternity services from the gateway of general practice. This study has shown that women on methadone maintenance do attend with their children and receive gender specific care which they value. The findings suggest that the co-ordination of care and support for women during the vulnerable period of pregnancy is available in primary care however these findings highlight a need for co-ordination of care to be strengthened between specialist services and general practice.

Men also valued their GP and this was expressed by the majority of the participants. This value placed on general practice has resonance with the recent 'Essence' study carried out in the UK which sought to distill the essence of general practice from the experiences of the general public and doctors themselves (Gillies *et al* 2009). This work was conducted over four years as a constructive response to changes in general practice and used commissioned short pieces of 100 words from GPs and patients. Questions such as- *What do you value from your GP?* identified similar concepts such as being treated as an individual, valuing the GPs' attention and time and valuing the ability to consult well. Feedback from service users both male and female in this study have identified for the first time the importance of the treatment encounter with their GP who "knows them" in relation to methadone treatment. This is noted as being significant, as rather than being treated as part of the collective drug using cohort that attends a treatment centre, they are treated individually. This is important finding as recognising individuation is an important component in a process of transformation from drug misuse to recovery (Etherington 2008). Identities are defined within interactions with others and are dependant upon the social discourse that is available. An important part of the process of maintaining and reforming one's identity lies in the individual's ability to interpret the messages which he or she receives from others and to accept, reject or modify them (McIntosh & McKeganey 2001). The treatment encounter with the GP has the potential to influence this process of recovery either negatively or positively. The training and equipping of GPs in this respect needs further focused attention and as identified in the review of the literature, there have been calls for the specific training of GPs in the RoI which equips them in reflective approaches to patient encounters (O'Riordan *et al* 2008). This reflection on the consultation may assist GPs to

recognise those service users who require psychological care in the recovery process from addiction.

General practice was indeed identified as a place to develop relationships. The doctor-patient relationship appeared to be facilitating the “normalization” of the service users’ drug treatment and therefore fulfilling one of the primary reasons the MTP was initiated into general practice from the perspective of service providers. Many of the service users (70% Appendix 7 Table 9) were attending their GP for five years or more and as identified in the literature review, length of time in treatment has been found in many studies to be one of the most consistent predictors of favourable post treatment outcomes among drug misusers (Gossop *et al* 2001). However despite the emphasis on treatment duration which is a measure usually attributed to treatment effectiveness from a service provider perspective, the majority of service users described personal relationships with their GPs and being listened to, described by Rosin as in *itself a cure*. Continuity of care with the same doctor was described and service users told of a repeated consultation pattern with the GP who knew them. In many cases “knowing the patient who has the disease” has been identified as important as ‘knowing the disease that patient has’ (McCormick 1996). As identified by Holt (2007:1938) this ‘know ability’ of the treatment context and also the apparent change in status of the drug treatment client from ‘autonomous agent’ to ‘participant in treatment’ is significant. Experiences of the service users attested to a long term personal doctor–patient relationship which has previously been identified as important (Freeman & Hjortdahl 1997, Stokes *et al* 2004). This was not only defined by the unique nature of the doctor-patient relationship (Balint 1964) but also described by service users as (similar to the RCGP definition) a ‘knowledge’ and ‘trust’ engendered by a familiarity with past care where their doctor recognized their professional

responsibility to their community (RCGP 2009). This past care was identified succinctly by Attracta: *sure he knows me since me mother had me, she's been bringing ... well lord have mercy on her she's a long time dead now but I remember going to him when I used to sit on the big huge pram.* General practice has been described 'as a place' where diseases come and go but patients stay whereas hospital has been described 'as a place' where patients come and go but diseases stay (Heath 2005). Recent changes in family practice in some countries encourage large multi-physician groups where it is unlikely that a patient will continuously see the same doctor (Agarwal & Crooks 2008) yet in the RoI this situation is not commonplace. Continuity of care is seen as an indicator of quality in general practice and was valued by the frequent attender on maintenance therapy. Some patients such as Erica saw their GP every week *-like every week fifty bleeding two weeks a year.* This relationship building underlines the importance of what Lilly *et al* (2000) described as 'sociality' in treatment. This study emphasises that the interaction with the GP is viewed not just as a medical encounter but fulfills an important social function. *I wouldn't see anybody in the week or the only person I'd see would be Dr.X,.. and I actually felt a lot better walking away like he does... he's a caring man.*

However although the majority of service users described a good relationship with their doctor paradoxically the potential for another type of relationship was also described in the data-“the phy doctor” (Physeptone). Three service users recounted a rushed consultation pattern when attending their GP. They perceived a lack of interest in their emotional well being and lack of experience in understanding drug addiction. This finding highlights the importance of the GPs' ability to consult well as identified in the Essence study (Gillies *et al* 2009). Investigating methadone dosing in Victoria investigators found that for their service users, a proactive and even interventionist approach was favoured in the consultation—this was an approach that required greater

resources for service providers to either spend more time with patients or to have support staff who could do so (Lintzeris *et al* 2002). As discussed in Chapter 1, lack of therapeutic engagement (Wilkinson & Mistral 2003) and physicians attitudes (Fitzpatrick 2001, Grehan 2007) can affect the relationship between patient outcomes and elements of the therapeutic process which should be addressed in the consultation (Simpson *et al* 1997, Towle *et al* 2006). Thus significant factors in the experience of effective treatment appear to be the building and preserving of relationship and rapport between service users and service providers and providing a quality service which is dependant on the caliber and characteristics of the service provider and respect and dignity of the individual (Fletcher *et al* 1997, Lilly *et al* 2000).

In the light of this data consideration of the proper role of the methadone-prescribing doctor is required. Issues of prescribing power identified in the literature review present an opportunity for control and the potential creation of obedient subjects rather than a partnership approach to care (Burgois *et al* 1997, Keane 2009). Drug misuse is associated with a range of health and social problems for both the community and the user (Ward 2002). Acting first to reduce social suffering, the GP needs to be cognizant of the whole picture. Patients can consciously conceal problems because of shame and or guilt and they can avoid disclosing painful facts. Non disclosure and denial coupled with the GPs lack of time and perhaps specific training means that the goal of the consultation is not achieved. These goals are expressed as obtaining accurate information about the substance misuse, achieving consensus about what behaviour requires attention and arriving at a mutually acceptable plan for treatment. These may conflict with the patient's pattern of avoiding acknowledgement of the problem (Billings & Stoeckle 1999). This highlights an approach to practice advocated by Rhodes which understands how context

influences health and vulnerability in general as well as drug-related harm specifically (Rhodes *et al* 2003, Rhodes *et al* 2005).

As identified in chapter one, the role of environmental–contextual factors in limiting the ability of drug misusers to embrace individual behaviour change in order to reduce drug-related harm has not been addressed adequately up to this juncture (Moore & Dietze 2005:1). How the addict identity and lifestyle are developed and the changes that must occur in order to create a transformed identity have great significance for treatment. General practice needs to be aware of this transformation and reconstruction of identity and not assume that identity is fixed by the identity constructed due to the substance of methadone. Pathways to recovery and transformation have been advocated in this respect but specific training is required (Etherington 2008). These issues need to be divulged in a confidential and safe setting and service users spoke positively about the assurance general practice afforded them within the GP/ patient consultation.

Confidentiality described as, *a place which is confidential*, was seen as paramount. These views were again described in contrast with service users' experiences in treatment clinics. Reflecting back on the initial literature review, the importance of confidentiality was identified by O' Reilly *et al* (2005:9) who detailed this expressed concern of service users attending treatment clinics. These participants recounted that people *who should not know their business, did*. Some users regarded the use of identifying stickers on their charts and the use of signage, such as "infectious diseases", as insensitive and stigmatizing. Recent research from a consumer satisfaction survey by service users at the National Drug Treatment Centre also suggested that service users have sought more privacy while accessing treatment. (Ambreen *et al* 2008). When confidentiality was lacking, as in the reception area, informants felt exposed and three incidences were described in two separate

general practice sites which were attributed to the lack of confidentiality among reception staff. In light of these findings, GPs need to consider the lack of privacy in the reception area and how this aspect of service can negatively affect the treatment encounter. Recent observational research in general practice has shown that small changes would make a big difference in terms of improving confidentiality at reception. Breaches could be minimized to enable practices to comply more closely with codes of practice for handling patient-identifiable information, which in turn would improve the patient-clinician relationship (Scott *et al* 2007).

Describing general practice as *a place to get clean*, service users experienced a place where they visited as a regular attendee and could have their medical needs met at the same appointment, if they considered it necessary. This study shows the location of the treatment environment of general practice to be beneficial for the service user. The treatment centres in Dublin provide methadone through a multidisciplinary team approach and typically are large centres providing services to between 100-300 patients (Delargy 2008) where dealing in the vicinity is widely known (Ambreen *et al* 2008). It is not surprising therefore that they are not seen as *a place to get clean* as congregation of other drug misusers is commonplace. Service users described a place where there was little if any congregation outside the surgery doors although there was a specific area to buy extra diazepam and/or night sedation identified by two service users-this at a location away from the surgery.

Service users described that general practice provided an opportunity to consider reduction strategies and offered *a place to reduce*. The experiences of those who chose to reduce with the support of their GP were reflected in the data. Sometimes this support caused

complications in relationships as two participants expressed that they did not wish "to let the doctor or nurse down" by not reducing their methadone dosage. These service users also expressed anxiety about not "coming clean" in relation to buying extra methadone. They did however feel comfortable after a period of time and did discuss these issues subsequently with their GP. Both were satisfied that their dosage of methadone was increased until they felt ready to reduce again. Reflecting on the literature review, Parr *et al* (2008) suggested that raising the issue of cessation of benzodiazepine use systematically with every patient who had been prescribed benzodiazepines for longer than three months and recommending that they gradually reduce the benzodiazepine dosage, is likely to result in better cessation rates when compared with continuation of routine care. This also holds true for a slow reduction of methadone advocated in general practice as one approach to treatment which requires flexible, separately negotiated dose reductions (ICGP 2008). In this study the data implies that there was evidence of care planning and shared decision making in reduction strategies. This is in contrast to the findings of O'Reilly and O'Connell (2006) who described a 'one size fits all' approach that favoured maintenance. Service users were included in decisions about the dose of their prescribed methadone and as the literature suggests, attention was paid to strategies that support reduction and cessation of maintenance and thus improve patients' expectations (Chalmers *et al* 2007). Partnership in care was evident as service users attested to treatment approaches which were individualized with the service user in control and active as partners in their recovery process. Self reported data from two of the sample described their own erratic drug misuse and buying extra methadone. In this situation the GP was described as being in control of dosage. A partnership approach was described in relation to the doctor/patient relationship which facilitated reduction strategies.

Multi-morbidity is common among problem drug misusers attending general practice for methadone treatment and the identification of a *place to sort things out* reflects the spectrum of care and level of service provision required for those on MMT. The data suggest that this provision of service is a priority for the service user. Addiction treatment systems in many western nations (and Ireland is no exception) developed in relative isolation from primary health care and mental health treatment and have focused on alcohol and or drug misuse. Miller & Miller (2009) argue that such an approach is outdated for mainstream treatment for addiction to drugs such as heroin. They suggest that when entering specialist treatment, people bring with them a 'vast array of other concerns', some of which are often of higher subjective priority than stopping substance use. These require additional support services than what is available in the majority of general practices. Cullen *et al* (2009) conducted a recent cross-sectional study of patients attending three large urban general practices for methadone treatment in Dublin and this sample was compared with a control group matched by practice, age, gender and General Medical Services (GMS) status. A wide range of chronic illnesses that had not been predetermined were recorded among patients on methadone treatment and these patients attended their GP and other healthcare professionals in the practice for issues other than their addiction care. The authors concluded that primary care has an important role in primary and secondary prevention of chronic illnesses among this population.

The findings suggest that, similar to the findings which identified service users' 'ideal methadone service', physical needs were attended to at the same time as the 'methadone consultation' (Jones *et al* 1994). There was one exception to this as one general practice had a separate time for drug misusers. This echoed the views of O'Reilly and O'Connell (2006) who highlighted this situation as one which they felt enforced a

segregation which prevented the holistic approach of partnership in care in general practice services. The service user interviewed in this practice however spoke of a good relationship with the GP although a separate appointment for physical health care was required. This was the outlier in the study as all other service users could avail of medical services at the time of contact. Sorting out general issues that need sorting has been described as an activity related to the scheduling of methadone dosing in Ireland specifically in the context of treatment clinics (Saris 2008). General issues are sometimes key issues for service users such as housing concerns, social and forensic problems which require the all important GP letter for the Housing Corporation and social welfare systems. For many clients, the provision of these services from GPs, leave little space for targeting lasting change in drug misuse until these issues have been addressed (Best *et al* 2008). This co-ordination of care is the daily stuff of inner city general practice (RCGP 2005). Joint working across health and social care is therefore a key feature of effective treatment.

One of the special features and strengths of drug treatment in the UK is the valuable partnership between statutory NHS drug treatment services and non-statutory or voluntary sector drug treatment providers, which comprise up to half of service provision in some local areas (DoH England 2007). This is not the case in the RoI and drug misusers with 'complex needs' are a resource-intensive group, which provide the greatest challenge for service providers (Cox *et al* 2007). Many drug misusers have a myriad of health and social problems, which require interventions from a range of providers. This provision of care requires a multidisciplinary approach however the influence of nurses was relatively unexplored by the service users and practice nurses featured sporadically in their dialogue and more often than not in relation to task orientation. Although GPs and practice nurses are central to the

delivery of primary care services in the United Kingdom the role of practice nurses is still underdeveloped (Mistral & Velleman 1999, Copello *et al* 2009). The unexplored and hidden role of the practice nurse in the RoI had been highlighted in the previous study undertaken by the researcher *Perceptions and Experiences of Practice nurses in relation to patients on a Methadone Treatment Protocol* (Latham 2003). The findings of that study identified that nurses felt they had a significant contribution to make in the day to day management of patients on a MTP. This contribution was identified as practical input into relapse prevention, providing a relationship of support, non-judgmental attitudes (therapeutic neutrality) and an important function of 'just being there' for the patient (Latham 2003:98). Opioid misuse is often characterised as a long-term, chronic condition with periods of remission and relapse and abstinence although it may be one of the long-term goals of treatment, is not always achieved (NICE 2007). The requirement for additional psychological assistance within the framework of service provision in general practice is therefore important. Nurses themselves identify a psychological domain of practice as central to their work ((WHO 1996, Latham 2003, MacNeela *at al* 2007) and recognize that they can deliver psychosocial interventions. In this study service users did not recognize this nursing support as particularly significant to them. Two nurses had completed the Level I training course (one being the researcher). The management of a population of patients with chronic and often complex medical, psychiatric and social conditions without the ancillary support of nursing or a primary care team poses the question: is this an adequate model of care? Given the slow implementation of primary care teams and rolling out of the primary care strategy nationally, the further expansion of teams has been documented as an unrealistic expectation (Stewart 2008). A more proactive role on the part of practice nurse may be required to effect change in this respect and the

ICGP should acknowledge their role in this respect, although overcoming what has been described as 'professional straitjackets' where roles are clearly demarcated and rigid has not traditionally been easy for practice nurses (Muncey & Parker 2001). As highlighted by Fischer *et al* (2008) structural factors such as these which affect service provision all require consideration.

The lack of service provision in relation to the availability of formalised counselling emerged from the data, expressed as—what could not *get sorted*. Service users described their wish not to have to re-engage with treatment clinics for this service as they had progressed in their treatment trajectory to general practice. These findings are in broad agreement with similar findings described in the literature review. GPs in Dublin had expressed the necessity for improvements in a range of services notably counselling, psychiatric support and nursing services (Wilkinson & Mistral 2003). More recently GPs participating in the MTP were asked what additional services would enhance the care they could provide for patients and 52% of respondents chose addiction counseling as their first choice (Delargy 2008). Although service users have endorsed concerns about their psychological health within HSE addiction services in Dublin (James *et al* 2008), many within this study did not wish to attend counselling. Three of the surgeries visited for the study had on-site or co-located counselling available. The idiosyncratic nature of responses to counselling resonate with the findings highlighted in the literature review (Wilkinson & Mistral 2003) however location of services was not considered. The HSE employs a total of around fifty one whole time equivalent counsellors to assist persons with addictions in the greater Dublin area (Buckley 2009). Presently two types of psychological services are provided in primary care. They are known as "co-locational" and "autonomous models". Autonomous as the name suggests, is a stand alone service providing psychological

support to a selected community in a building designed for this purpose. All clients are referred from their individual GPs and travel to the centralised location for therapy. The co-locational model affords the client the opportunity of attending the psychological service in the same building as their medical team (O'Grady *et al* 2008). O'Grady explored the experiences of clients who are currently engaged in psychological therapy in a primary care setting in Dublin and found that the co-located nature of the service provided a familiar but anonymous and confidential setting which had the result of reducing stigma of attending the psychology service. This location of service and setting again reflects the importance of treatment context within general practice, however these co-located models are scarce and may not in the current economic climate be replicated for some time. Martin *et al* (2009:284) when documenting psychological services for adults in primary care in Ireland have stated that anecdotal evidence from GPs suggest that assessment at primary care level is their first choice for patients and for some patients, primary care is the only acceptable route into psychological services. The psychologist as an integral member of the primary care team was not the original model envisaged by the Irish *Primary Care Strategy* (2001). Recognizing that psychological services are a relatively new concept in the Irish context its integration represents both a cultural and cognitive shift. This shift is not one which is only required by the medical profession but also 'within the societal framework as represented by the service user' (Martin *et al* 2009:287). These issues need further exploration.

6.3 THE SIGNIFICANCE OF METHADONE FOR THE SERVICE USER AND THE EFFECT OF SUBSTITUTION TREATMENT ON THEIR LIVED EXPERIENCE.

Service users described their experience of methadone and the significance of substitution treatment in their lives. The feelings service users attributed to methadone and their descriptions of *what methadone does for the service user* vacillated between their past experience of their addicted lifestyle and how they felt about the substance of methadone as treatment for heroin addiction. Most realized the significance of methadone in the recovery process but many also despised the drug and their subsequent dependence on it. Despite these negative feelings consistent with the established literature (Fraser & Valentine 2009), service users recognized the benefits of methadone in terms of their personal health, reduction in crime and virus protection (Ward 2002).

General practice was recognized by service users as a place which provided access to viral screening and individual viral status was known by the majority of the participants however hepatology treatment did not feature as being important. Only two of the service users described that they had followed up on treatment for HCV with the encouragement of the GP. General practice has demonstrated that the majority of patients have been screened (Cullen *et al* 2007) but follow on care for those infected with HCV has been poor. This situation points to the importance of scaling-up harm reducing interventions for HIV and HCV prevention (Aceijas & Rhodes 2007). This is a global priority especially in settings where available estimates suggest high HCV such as the Rol (62-80% ICGP2008). This data emphasises that further efforts are required to encourage service users to attend for treatment once HCV is detected.

Feelings about the drug itself and dependence on it (liquid handcuffs) provoked responses about the meaning of being addicted to the substance of methadone and the urban myths which surrounded the use of it. The lack of knowledge about methadone and the accepted myths about its use such as methadone "getting into your bones" and the various other attributes drug misusers ascribed to methadone, highlights a lack of health education in general practice. This finding has resonance with the work of Winstock *et al* (2008) who identified a significant lack of knowledge about some of the effects of methadone and buprenorphine among 956 clients receiving treatment for opioid dependence at 9 public clinics and 50 community pharmacies in New South Wales, Australia. As a result of lack of education suboptimal use of medications and ambivalence over treatment can be problematic and the provision of written material can potentially prevent this. The availability of such literature is in question as the "green book" which was alluded to in the interviews was the Irish edition of the *Methadone Handbook* (Preston & O'Connor 1998). This resource has not been available in the RoI for several years and is only accessible on-line. This poses a barrier to effective education which is significant as it would have to be imported at a cost to either the service provider or user. There are other aspects to education which require specific guidelines. Opioid treatment programmes in the United States have recently been challenged with providing education specifically in relation to integrating cardiac arrhythmia risk assessment into routine care. New concerns about methadone and its pro-arrhythmic properties have emerged and clinical guidelines recommend disclosure about multiple factors which may contribute to drug-induced arrhythmia. Guidelines on clinical history taking, screening, risk stratification and drug interactions have been issued (Barclay 2009). This type of disclosure has not evolved in the RoI despite the fact that the *Report of the Commission on Patient Safety and Quality Assurance* (2008) recommends

communication and open disclosure with service users on a range of issues. No service user described educational forums in general practice which explained to them either the pharmacology of methadone or the side effects associated with taking the drug. This data has implications for professional practice and suggests the urgent need to consider systems to ensure that clinical information concerning treatment is received and understood by clients.

Methadone is currently the only licensed treatment for heroin addiction available to GPs in the RoI. Buprenorphine is not licensed for use in general practice although available in HSE treatment clinics. The absence of any other form of treatment other than methadone fuelled responses such as that by Sean: *they could have coming up with a better drug than Methadone and is there a better drug to get, have they got a better way of getting you off drugs?* This notion of pharmacological optimism requires further investigation and has been discussed in a limited way in recent literature (Keanna & Wood 2008). There is limited evidence comparing buprenorphine with methadone, but a recent Cochrane review suggests that completion of withdrawal may be more likely and withdrawal symptoms may resolve more quickly with buprenorphine (Gowing *et al* 2009). Consideration of other forms of pharmacological treatment options is well overdue in the RoI.

The importance of *normality* and *stability* was frequently emphasized throughout the interviews as participants described what methadone means to them. Feeling “normal” was attributed to being able to carry out everyday tasks, looking after children and learning to be stable. Normality was understood as functioning with methadone, keeping a job, going back to education, keeping to a routine and structure. Stability was described as being able to move on with life without the need to look for heroin, being able to relax, being “like other mothers”.

Another hidden aspect of stability was the economic benefits accrued from both selling methadone which required non-compliance with the treatment regime. The average cost of street methadone is currently €23 per 80 mgs (Roche *et al* 2008). Chalmers *et al* (2007) describe two issues here, selling prescribed methadone to obtain a source of income and non-adherence to methadone as originally prescribed (for e.g. halving doses). There are substantial harms such as overdose associated with both non-compliance and diversion. Both undermine the viability of the MTP and systems need to be put in place which will address these issues.

Descriptions from service users identified *the importance of street trading*. The data show clearly that the environment of drug addiction co-exists in parallel with harm reduction treatment. Methadone treatment related problems such as diversion of methadone are associated with maintenance programmes (Fischer 2000). Both street methadone and benzodiazepines were traded. As identified in the review of the literature the local level drug dealing environment is an important feature of local economies in marginalised communities (Fitzgerald 2009). Buying extra and diversion of methadone highlights the issue of reciprocal care and responsibility towards other drug misusers, the economic disadvantage of service users and often the unmet demand for treatment. These dynamics have been identified by Fraser *et al* (2007) who reviewed MMT in South Australia. They warn that the issue of methadone diversion should be a major concern for all MMT programmes and highlight that the potential for diversion is increased with take home privileges. The majority of methadone related deaths have been directly related to illicit methadone diversion (Varenbut *et al* 2007). There is no doubt that when methadone dispensing is commenced initially concomitant usage is the norm and expected and is a reason for adjustment of dosage (Heinman 2000). In

this study however the majority of service users had been receiving methadone for more than five years. Methadone related deaths are associated with maintenance programmes (Roche *et al* 2008). Data from Ireland estimates that opiate related death rate among the opiate–using population was 64 per 10,000 in 2001 (Long *et al* 2005). Two–thirds of the opiate users who died tested positive for three or more drugs (Byrne 2001). Ward and Barry (2001) estimated 84 opiate related deaths in 1999 and identified that 45 (54%) were methadone related, 15 (33%) were receiving prescribed methadone. Roche *et al* (2008) identified that illicit methadone use was readily available among a cohort of 81 young people (15-25) attending a Dublin treatment clinic where a culture of methadone diversion was evident. It appears that poly-pharmacy, the co-prescribing of benzodiazepines, tricyclic antidepressants, and other opiates, will have contributory effects on the risk of sudden death in patients on a methadone treatment programme, particularly in patients with co-morbidities that affect drug metabolism (Fahey *et al* 2003). Concurrent benzodiazepine misuse in the management of MTP patients is a problem and evidenced in this study. This problem is widely known and has not been consistently tackled (Corrigan 1986, Farrell *et al* 2000). Only 45% of doctors surveyed in the recent ICGP survey felt that training had prepared them satisfactorily for this associated co-addiction and as a recommendation of the survey it was suggested that GPs become familiarized with the guidelines on benzodiazepine prescribing issued by the DOHC (2001) (Delargy 2008). The recommendations of the benzodiazepine committee set out to address this inappropriate prescribing and suggested a monitoring system. This has not been put in place. These findings support the identification of a monitoring process in relation to benzodiazepine prescribing.

The need to buy extra methadone also raises the discussion about optimal dosing which has arguably been set at doses in the range of 60-

100 mgs (Chalmers *et al* 2007). Service user preference for lower dose methadone has been identified as a significant barrier to optimal treatment (Lintzeris *et al* 2007). The findings highlight the need to revisit the rationale for prescribing benzodiazepines and low dose methadone. This may also be achieved by developing the communication and negotiation skills of doctors in this respect. Logistical difficulties created by perhaps patient load and time constraints may need to be addressed and alternative treatments such as buprenorphine and valid non-pharmacological alternatives to benzodiazepine use should be explored (BYAP: 2004:15).

6.4 SERVICE USERS' EXPERIENCES OF BEING INVOLVED IN DECISION MAKING AND MANAGEMENT OF THEIR TREATMENT.

Service users described their experiences in the past of being involved in a system which historically laid the foundation for the current protocol. They described *why the protocol was necessary, what the protocol currently means to the service user and what their understanding is of what influences the implementation of the MTP*. In this way they also described their level of involvement in their treatment. As discussed in the review of the literature most Irish GPs were disinterested in, if not antipathetic to the idea that they should play a major role in the management of drug addiction prior to the introduction of the MTP in October 1998. Butler (2002:312) suggested that a very small minority were enthusiastic and were 'committed to doing so to a high professional standard' but there was at that time a small but indeterminate number of 'rogue doctors' who were exacerbating societal opiate problems and bringing their profession into disrepute by prescribing irresponsibly. Prior to this study these sentiments were only every supported by anecdotal reports comparing 'rogue doctors' with backstreet drug dealers (Delargy 2001, Butler 2002,Saris 2008).

Regulatory scrutiny of private practice in the UK has also been identified as being inadequate (Strang & Sheridan 2001). Service users described in detail their dealings with these private doctors and attributed the establishment of the protocol to this historical situation identifying *why the protocol was necessary*. What was concerning in the study was that service users insisted that the practice in relation to benzodiazepine prescribing was still ongoing and told of elaborate stories which their associates were encouraged to fabricate in order to legitimize their procurement of a prescription. The DOHC (2001) recommended that the small number of doctors, who may have been prescribing inappropriately, putting their patients and others at risk, should be identified, investigated and dealt with accordingly. Over the years these powers have been availed of on only a few occasions and (Buckley 2009). These findings urge further considered focus in this respect.

Descriptions of *what the protocol means to the service user* involved service users' understanding of the daily workings of the protocol rather than the semantics of the word protocol which did not appear to be of significance for the service user. What the protocol symbolized was described as an escape from the ravages of heroin addiction although some respondents initially understood the protocol as providing a method of detoxing. When commencing a MTP it was apparent that full understanding of what it would mean to be on maintenance in the future was not understood. There was acknowledgement on the part of service users that the government was "stepping in" and that something had to be done to prevent poor prescribing practices however the daily working out of the protocol or regulatory rules were understood in terms of *knowing the rules* and *working the system*. Knowing the rules involved 1) urinalysis, 2) supervision of ingestion at the chemist and 3) attendance schedules. Working the system involved

intricate ways of circumventing these rules.

All service users understood the importance and agreed with regular urinalysis which was a significant part of *knowing the rules* of the protocol. This is a finding which is in stark contrast to the findings of the UISCE report (2003). This report suggested that the process of supervised urine collection was degrading and there was a lack of confidence in urinalysis as many claimed to have obtained incorrect results. This was not a finding attributed to this study but rather the contrary view was upheld. The participants were concerned that not enough attention was attributed to the guidelines on supervision of urinalysis which they felt had a significant effect on treatment. Stories emerged of drug misusers dealing in "bogey" urines, providing someone else's specimen and the deception involved in avoiding giving a specimen contributed to the problem of methadone diversion. Service users described situations where they felt guidelines were not being adhered to which led to feelings of frustration and injustice. Two of the service users who expressed their concern about their relationship with their GP had urinalysis every week which was supervised. However once this aspect of the consultation was achieved they felt that the clinical assessment was lacking. Aaslid in his thesis on *Facing the Dragon* identifies that successful treatment should not be measured primarily by the number of clean urine samples but by the extent to which clients are able to consciously connect with and process their own patterns, integrate them into a lifestyle that works for them and allow transformation to emerge at its own sustainable pace and rhythm (Aaslid 2007: 222). The ICGP guidelines (2008:12) point out that urine screening is not a substitute for clinical assessment of the patient. One of the service users was selling a vast amount of her prescription and another was supplying his wife with a weekly dose as she did not want to sign up for a maintenance programme. Attendance schedules were not consistent and deviated from recognized guidelines. One service

user who was unimpressed with her 4-6 weekly consultations reported that she had never had a supervised urinalysis in six years and was supplying her brother (who was registered with the same practice as she attended for MMT) with bogey urines. All of these issues could potentially have been clarified by open dialogue at consultation and adherence to recommended guidelines, which is what the service users claimed they wanted.

Other factors such as supervision of ingestion in the chemist revealed further deviation from ICGP guidelines. It is recommended that a minimum of one dose should be supervised weekly even if the patient is stable (Chapter 6). Six service users were unsupervised in the chemist and were allowed to take away doses as large as 90mls without supervision of ingestion. Further deviations from guidelines exposed attendance schedules as erratic and inconsistent. Some service users attended weekly, others two weekly and others described seeing their GP six times a year despite a methadone dosage as high as 150mls. Another attended four to six weekly despite a methadone dosage of 80mls and being prescribed benzodiazepines by a GP who she was not registered with for MMT.

The descriptions proffered by service users regarding supervision practices in the chemists warrant further investigation also into an important link in the chain of care. Historically, the *Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone* (DOH 1993) recommended that methadone should be dispensed in the same manner as any other similar medication. In her review of the pharmaceutical services for patients in methadone treatment in Ireland, O'Connor (2003:143) stated that while respondents to her questionnaire supported the theoretical idea of on-site supervision; they experienced difficulty with its delivery. She also described an underlying tension in the relationship with service users which is still prevalent. The suggestion that negative experiences hinder

engagement with pharmacies has been visited in the literature (Neale 1999b) and service users have frequently expressed the desire to be treated 'normally' (Matheson 1998). Scott and Mackridge (2009 a & b) undertook a recent study in the UK to examine involvement of pharmacy support staff in delivering services to drug misusers investigating a random sample of 10% of UK community pharmacies (n=1,218). Six hundred and ninety (56.7%) pharmacies responded, and 1976 completed questionnaires were returned from 610 (50.1%) pharmacies. A further 80 (6.6%) opted out. This was the first known study that examined attitudes and involvement of UK pharmacy support staff in service provision to drug misusers using a nationally drawn random sample. It was identified that nearly three-quarters of staff working in pharmacies that provide drug-misuse services had not undertaken training on such services. A relationship between attitudes, training and service provision was identified, with practice exposure and training combined linked with more positive attitudes than either aspect alone. Similar to O'Connors' study, the quality of the service experienced by the drug misuser in this work has been found to be questionable. The *Pharmacy Act* (2007) empowered the Pharmaceutical Society of Ireland to commence a review of pharmacy services and pharmacy practices in the state. One of the recommendations of the society was to critically appraise the strengths and weaknesses of the current pharmacy system in Ireland (Pharmacy 2020). This system of care, expertly documented in O'Connor's thesis has changed little with service users still expressing difficulties with lack of confidentiality and conflict at the interface with supervisory arrangements. Other issues such as non-adherence by the pharmacist to the GPs prescription were described by Olwyn, Erica and Molly who negotiated dose division and change of supervisory details.

Multifactorial contributions such as these are critically important in methadone-related deaths. The issues described here are important in relation to professional practice. As identified in the literature review, deviation from guidelines is common in practice (Matheson & Pitcairn 2003) however prevention of methadone related deaths requires adherence to prescribing regimens from both the prescriber and dispenser. There should be a willingness on the part of the GP to modify prescribing practice when faced with changing patient behaviour (Fahey *et al* 2003). Behavioural change can be elicited by knowing the patient and recognizing the factors that influence the regulation and implementation of the MTP. Factors such as these are complex and involve the dynamics of treatment encounters, treatment programme design and structural factors which were identified in chapter one as affecting service provision (Fischer *et al* (2007, 2008).

The rules of the protocol and the myriad ways by which they were interpreted by GPs, and pharmacists were inherently known to the service user. Service users found a way of *working the system* to their own advantage as Olwyn explained *you learn how to play them you know what I mean?* This involved an *understanding of what influences the implementation of the MTP* which made allowances for the integration of many players in the system. These players were identified as other drug misusers, GPs and pharmacists. There are in fact four main beneficiaries of the MTP who all benefit in financial terms from the MTP as this includes the service user themselves. The data describe the significant pressure which is exerted on those on methadone maintenance to look after or “sort out” those who are not stable, whether it be family, friends, acquaintances or simply those they know from their previous identity such as those involved with criminality.

GPs were identified by the service users as those who wished to help their patients first and foremost but it cannot be denied that a generous remuneration package is provided (Barry 2002) which may influence the

future implementation as more doctors are encouraged to take on patients. Daithi identified that the GP *could make a lot of money* out of the MTP.

Pharmacists have a significant influence on the protocol also and benefit financially from each patient. A pharmacist recently commented in *Irish Pharmacist* that he had hoped that the MTP would 'put his kids through college' (Jordan 2008:28). It is interesting that the total cost of Irish primary care based methadone maintenance treatment in 2007 was approximately €14 million. Of this total, fees to GPs amounted to €5.3 million, while fees to community pharmacists were €5.9 million, and the total cost of ingredients was a further €2.8 million (Buckley 2009:41).

The final beneficiary however is the service user themselves as unlike other countries such as Australia (Chalmers *et al* 2007) methadone is free to the user and they in turn can and do benefit from selling it on the black market.

These findings arising from the data require further investigation. As highlighted by Farrell *et al* (2000), there is a clear need for ongoing training, support and the development of innovative modes of communication between clinicians, pharmacists and service users to address these issues related to professional practice.

Conclusions and recommendations for practice are summarized in the following chapter.

4th Bracketing Interview

P How in terms of the practice you work in, how could you see this evolving into a more comprehensive patient care model...now assuming of course that they would agree to a more comprehensive patient care model. Could you see yourself moving beyond the quick fix as a practitioner?

R Yeah I personally feel that I have moved beyond that because I have the benefit of a multidisciplinary team and the benefit of a counselling psychologist in the practice. We have the benefit of the services that are provided there. However of our 65 patients not a huge amount of them opt for that because we haven't educated them to know that there is another piece to this addiction, partly because we haven't got the time. Mostly... but partly because it isn't seen nationally as something that would involve a multidisciplinary team and that is very different to the models anywhere else in the world ...

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

This study investigated the micro-setting of methadone treatment in general practice in Dublin illuminating the social meaning and practices associated with this harm reduction treatment. It also cast light on the macro setting of policy context and methadone protocol design. Results from this study can be transferred to other contexts and settings as transferability has been enhanced by richly described data. The data provides the research community with enough information to judge the themes and constructs of the study and it provides enough information to judge the appropriateness of applying the findings to other settings (Byrne 2001). The study design was not without its limitations. Self report may have affected participants responses where the researchers' position, as nurse, may have given rise to both participant and researcher bias. However the usefulness of addressing the service users' experience which has largely been neglected so far in the RoI has been proved to be worthwhile as many practical suggestions for change have been proffered as a result of listening to the accounts of their experiences. New information has been obtained by using this approach and by utilizing these methods some contradictory information to previous studies has been demonstrated. Future recommendations for research, in the light of the knowledge which has been gleaned from the study, are discussed.

Much of the grey literature up to this point in time has informed local knowledge and practice. The study findings contradict some of the small studies identified in the review of the literature (UISCE 2003, O'Reilly *et al* 2005, O'Reilly & O'Connor 2006). These studies asserted that service users were subject to methadone sanctions, discriminating

services and were being cared for under a “one size fits all” umbrella method of service provision in general practice. The existing literature had overlooked ways of clearly viewing the phenomenon of MMT in general practice. The views which service users articulated provide insight into novel experiences which have up to now been left unheeded. The process of “being heard” greatly improves our understanding of general practice provision and how it can be improved to benefit service users.

The findings of this study are novel as unlike quantitative research which can summarize key findings with numerical data, this research has achieved a deep understanding about how service users experience their treatment and this has been expressed in their own original way and language. ‘Actual care versus ideal practice’ (ICGP 2003) was investigated and found wanting.

7.2. CONCLUSIONS AND RECOMMENDATIONS

This study aimed to explore how the MTP was being implemented in general practice by describing the users’ lived experience of treatment, and their experiences of being involved in decision making and management of that treatment. What has been gained from this work is an insight into that experience and what the treatment trajectory creates. This work suggests that from the perspective of the service user there are both benefits and shortcomings in relation to receiving methadone treatment in General Practice in Dublin. The findings from these service users’ views can be translated into recommendations and there are many that can be proffered as a result of this exploration of their experiences. There are a number of implications for policy and service delivery that follow from the service users’ accounts of their experience of general practice however a tension remains as to how to involve service users effectively.

As acknowledged in the literature the presenting needs of service users accessing treatment services have been shown to be frequently bewildering in their complexity, often involving multiple substance use, physical and psychological health problems and relationship and family difficulties (Best *et al* 2008). Need has been defined, in the health care needs assessment literature, as 'ability to benefit' (Fountain *et al* 2000).

The major advantage and benefit of general practice identified in this study is that it provides a place where service users can avail of methadone treatment within an environment that they value. There is growing recognition of the role that place and setting can play in shaping the health of individuals and populations (Kerr *et al* 2007). The significance and social meaning of place in relation to the setting of general practice has been heretofore absent in the literature.

The overall personal, family and social functioning of the individual is being improved by methadone treatment however there were other issues of concern in relation to how child welfare should be addressed within drug treatment. Service users described differing issues in their lived experience of treatment which can be specific to gender or related to their past identity as drug misuser. Difficulties faced by drug-misusing women who are attempting to fulfill societal roles as mothers and provide the sort of childcare they and society wish for children has been highlighted in the literature (EMCDDA 2009). Female service users in this study attested to a supportive environment within general practice for their children and for themselves at varying intervals throughout pregnancy and child rearing. The development of a gender-sensitive perspective on how to support women who misuse drugs is long overdue (Grant 2009). Risk environments have been described and highlighted by Rhodes (2009). In this instance the risk setting affected not only the service user but also babies, children and families. Exploration is required into how the resilience of families and children in

particular can shape their own futures and how general practice can assist service users in this process.

The findings identify service users' satisfaction with the transformative environment of general practice which can assist in the development of a new identity as opposed to the past identity of "junkie". Identity is challenged within the environment of heroin addiction and the trauma involved in that lifestyle. Moving out of that lifestyle was described as difficult as identity had been fixed within that known environment. If identity plays as central a role in this process as the data suggests, and if this is interlinked with past traumatic experiences it is important to ensure that service providers in general practice are able to address issues of identity formation and change. Individual contexts can enable drug misuse and local contexts can shape local phenomena. Issues such as control, loss of freedom, stigma and labelling exist in Dublin but receiving treatment in general practice may "dilute" or "normalise" these feelings to some extent. Appropriate training is therefore required in identity formation and change which can help build awareness and knowledge among service providers and equip them to assist service users in this process. Further investigation into environments that enable change is required (Duff 2007).

The participants did identify that the treatment context of general practice provided a place which was fundamentally different from the environment of the treatment clinics, a place where potentially their drug treatment could be individualized. There was verbal evidence that the aims of the ICGP programme in relation to encouraging reduction strategies and supporting maintenance were being implemented by the majority of service providers. Service users spoke of valuing the confidential nature of the setting although there were instances where confidentiality was broken. Overheard disclosures can breach trust in the waiting room and among receptionists and all items of information

which relate to an attribute of an individual should be treated as potentially capable of identifying patients and hence should be appropriately protected to safeguard confidentiality (DoH 1994). Awareness of this could prevent stigma and unnecessary exposure for the service user.

The doctor/patient relationship was paramount and in general contributed positively to the trajectory of treatment which had a positive effect on patient participation. The research also identified tension and negative experiences of treatment with the doctor who consults poorly. This is a significant shortcoming which was identified within the treatment environment. A different consulting style was described and the term “phy doctor” was identified and contrasted markedly with the consulting style of the majority of the other GPs. The general practice sites which were surveyed were well established sites for methadone treatment. If this is a finding within these sites the potential for further poor consulting within other new or established methadone prescribing practices may be of great significance for future quality and standards in practice.

The majority of service users reported being mainly satisfied with their treatment however service users have historically few expectations of care. What a consumer reasonably expects to receive from a service has been shown to be influenced by the concept of ‘expectation’ and ‘relative experience’ (Madden *et al* 2008). Caution has to be expressed therefore as to what service users reasonably expect to receive from general practice as historically there is an absence of engagement with service users. Nationally negotiated service level agreements which include service users in the development process may assist this process.

This research showed that there is verbal evidence that the aims of the ICGP programme are being achieved in minimizing harm associated with opiate misuse such as crime and the associated health risks such as the risk of HIV and screening for HCV. Given the complexity of the service users self described needs it would be feasible to suggest that the GP needs assistance with care planning and delivery as is the norm with other chronic diseases in primary care.

The findings point to service users' satisfaction that general practice provides an environment which is providing a valuable service need for drug misusers. The general practice experience was sought after as a place where medical services were provided alongside drug treatment. This service may require significantly more resources and ancillary staff such as trained nurses and counsellors. There were variable responses to whether the location of psychological care offered mattered to the service user.

This data calls for a comprehensive review of the MTP with particular attention paid to ensuring that mechanisms exist to allow service users to feed-back their experiences and opinions. This requires considered engagement with both drug treatment service providers and users of drug treatment services. The findings inform service providers to consider how GPs and the wider multidisciplinary teams engage with the service user who is prescribed methadone. Supports for service users which include improved access to counseling and assistance in responding to methadone related issues that may serve as barriers to optimal treatment should be explored. This would involve targeted education about treatment plans, treatment side effects, withdrawal and potential for overdose. Service users will need support and training in the active planning and delivery of their own treatment. The focus could be to address client perceptions of treatment and broader psychosocial

needs. This at present is not possible to assess within the current audit system carried out by the ICGP and there is considerable variation in what services are provided. These broad recommendations for practice are further translated as the following:

- The ICGP who have responsibility for training and accreditation could consider a multidisciplinary focus which equips practitioners to identify psychological needs in association with prescribing methadone. The goals of the consultation need to be revisited and a comprehensive approach to service users' needs could be addressed.
- Practices should consider conducting patient surveys on aspects of confidentiality as a means of looking for ways to improve management of patient identifiable information.
- Training initiatives are required for general practice service providers to better understand the gender issues of treatment and how these issues reflect on those receiving treatment.
- Shared care planning initiatives and inter-agency working will be required to improve the liaison links between service users, general practice service providers and maternity and infant services which may assist understanding in this respect.

The significance of methadone for the service user and the effect of substitution treatment on their lived experience were described. The objective of treatment according to the NDS (2001) is two fold. First, to enable those dependent on drugs to reduce dependency, improve health and social well being and ultimately to lead a drug-free lifestyle

and second, to minimize the harm to those who continue to engage in drug taking (Cox *et al* 2007). Treating care planning in general practice as “treatment” is a realistic way to expect a treatment journey to be effective. The *Report of the Methadone Treatment Services Review Group* 1993 prior to the introduction of the 1998 protocol urged care in regarding methadone as an easy solution for a complex problem and warned that it should be regarded as an adjunct to treatment. The data suggest that methadone as a substitution treatment has emerged in a mostly positive light however as a substance negative emotions exist. As a drug methadone was both despised and lauded as a life saver. As an evidenced based harm reduction treatment, service users attested to its benefits in terms of reduction of heroin use, crime and virus protection. The meaning attributed to methadone maintenance was the provision of stability and normality for both the service user and the family but methadone was also described as economically valuable to the local drug dealing environment and provides an opportunity for reciprocal care for drug misusers. The importance of street trading was therefore enmeshed within the context of treatment. Service users expressed that an alternative to methadone should be made available.

These findings highlight the important question of prescribing practices and have implications for the current policy of control on methadone diversion which has been established as a cause of opiate related death in the RoI. The data also highlight the importance of understanding how environmental influences shape peoples lives and understanding of methadone. This challenges general practice service providers to provide appropriate information, resource educational forums and raise their own awareness of how optimal dosing can be achieved by developing their communication skills in practice.

The findings also identified the meanings attributed to the substance of methadone. Three distinctive features of methadone identities were uncovered which are original findings in relation to the consumption of methadone. These were co-constructed categorizations which were defined as “lifers”, “maintainers” and “reducers”. These new insights should aid practitioners to understand how service user’s view their treatment trajectory and inform them as to how this could be managed from their perspective.

There was sparse evidence that service users were educated about the effects of methadone and the dangers of poly-drug misuse. Coming into contact with primary care provided virus identification of HCV but little education about the effects of methadone. The realities of the complex phenomenon of methadone treatment is that methadone, although criticized as a substance which produces negative emotions (such as the “liquid handcuffs”) is a substitution treatment which remains valuable in many ways. This creates a paradox.

The research identified the risk associated with treatment which is inconsistent in its approach. There is a need to communicate information about treatment which is culturally appropriate to service users. The need to revisit the prescribing practices of GPs and the rationale for or against low dose methadone is called for. The findings indicate formal targeted education in this respect. This could include information about methadone, advice about the risks of overdose and emergency treatment. The data calls for consideration of these issues.

- A more pro-active role on the part of the practice nurse within a shared care system should be considered with a specific emphasis on educating service users on the importance of understanding the effects of treatment. Educational material to enable the service user

to understand the potential for overdose and emergency treatment should be developed with the involvement of the service user.

- Education for professional practice needs to be focused on development of interpersonal communication and negotiation skills with service users. This should incorporate a way of thinking about treatment dosage levels as a catalyst for change.
- The provision of an alternative to methadone such as buprenorphine could relieve service users of daily dosing regimes but would require a policy review of regulation to introduce and adopt this treatment option.

Service users' experiences of being involved in decision making and management of their treatment identified that the regulations of the MTP were subject to interpretation by service providers and many service users, recognizing this, circumvented the guidelines. The historical existence of "rogue doctors" was understood to be the reason the protocol was introduced in 1998. Illicit prescribing was still evident in relation to benzodiazepine prescribing. The protocol was well understood in terms of urinalysis, attendance and supervision of methadone. All these rules were subject to interpretation by service providers and many service users "worked the system". A desire for more stringent supervised urinalysis was expressed which would not only improve the system but safeguard other drug misusers who were being supported by methadone diversion.

Clinical practice guidelines are an important part of the evidence-based practice movement and one of the main tools intended to decrease practice variation, improve effectiveness, and establish which interventions in health care constitute 'best practice' (Bergmark 2009). Service users described ways in which these were not being adhered to in the delivery of methadone treatment and described a myriad of ways in which methadone is successfully diverted. This study suggests that

these avenues for diversion could potentially be significantly curtailed by the effective implementation of the ICGP guidelines. The interpretation of these guidelines needs to be explicit and rigidly upheld not only in relation to urinalysis and supervision of ingestion but also in terms of clinical assessment.

There is little evidence that the use of non-prescribed drugs by the individual has been reduced and in some cases there is evidence that the principles of safe prescribing, which help reduce the diversion of drugs into the illegal market are not being adhered to. The suggestion that rogue doctors still exist places a burden on general practice to provide strict guidelines on benzodiazepine prescribing that are mandatory. The recently published interim report for the *National Drugs Strategy* (2009-2012) suggests that the monitoring of private prescribing has proved problematic and 'needs to be addressed' (DOCRG 2009 4.37:48).

General practitioners who were involved in the MTP were recognized as committed to the community but there was a minority who were deemed to be involved because of financial gain-the so called "phy doctors". Relationships with the pharmacist were not well developed and indeed in some cases very poor. The role of the pharmacist as an integral member of a drug treatment team was underdeveloped with no evidence of liaison with the GP although it has to be acknowledged that service users would not necessarily be aware of inter-professional communication. Echoing previous reviews, it is obvious from the reports proffered by service users that better integration is called for between these professionals to improve quality and coherence of the local service (Farrell *et al* 2000). Action is needed on a number of levels to address these issues.

There is significant room for improvement in understanding how the delivery of methadone maintenance is only in part influenced by those that provide the service such as GPs and pharmacists but is also influenced and shaped by the local context in which methadone is prescribed. A desire for more stringent enforcing of the ICGP guidelines was expressed which could to some degree prevent methadone diversion as guidelines are currently being circumvented and interpreted in an idiosyncratic way. Providing methadone as treatment without the necessary checks in place for co-prescribing of benzodiazepines has created a narrow and risky view of methadone as treatment. These findings place a responsibility on service providers to implement change in how clinical assessment is carried out and how best to encourage disclosure about treatment adherence.

This study calls into question the effectiveness of current prescribing policies as the quality of medical practice in methadone and benzodiazepine prescribing was variable. Quality control of prescribing should be monitored and reviewed.

- A National body that carries out external monitoring of quality in methadone services should be formed. There is currently no National body that provides accreditation of addiction treatment services or that carries out external monitoring of quality as recommended by the Department of Community, Rural and Gaeltacht Affairs (2009).
- There is a need to review current practice in the effective implementation of the ICGP guidelines as they cannot be monitored by audit alone. An appraisal mechanism could be designed and implemented for this purpose.
- Benzodiazepines could be prescribed in a similar way to methadone with treatment cards and specific prescribing

scripts which are identifiable and therefore can not be subject to duplication.

- Service level agreements with service users need to be drawn up which establish a full description of services which can reasonably be offered in general practice.
- Multidisciplinary training initiatives involving pharmacists and the primary care team could help to encourage interdisciplinary communication links. Service users could be encouraged to be part of this process.
- A complaints liaison committee could be established to monitor complaints about the delivery of methadone treatment and to advise the ICGP/HSE and addiction services about potential improvements. To this end service users may need to elect a service user representative who could act as a facilitator in this regard within each practice.

Dissemination is required not as the end phase of this study but rather a continuous process of discussion, feedback and review between researchers and their participants (Booth 1988). The needs and characteristics of service users in this study expand the dissemination process beyond the written word to oral discussion, seminar discussions and workshops which may be altogether more effective. However until there are agreed quality standards and formal mechanisms to educate service users about their rights and the standards of care to which they are entitled these recommendations may not be best served by service providers.

7.3. REFLECTION AND CRITIQUE

This inquiry has shown that there is wisdom in viewing service users lives respectfully through their own eyes. This approach flies in the face

of a tradition that has dismissed service users' perspectives as hopelessly distorted, irrational and out of touch with reality (Miller & Miller 2009). This investigation of service users' views has been proved essential in that individual users have been regarded as the ultimate authority on their own process of care (Aaslid 2007). It has been recognized in this study that 'research for policy must be designed around users' information needs rather than the knowledge building aims of the academic community' (Booth 1988:248). With this in mind the gathering of information from those best qualified to give that information was vital to this study.

With the benefit of hindsight limitations of this study could be that excluding service users with psychiatric co-morbidity rendered the sample unrepresentative of the broader population of those in receipt of methadone who attend a Level 2 GP. Bias is possible by employing the strategy of maximal variation purposeful sampling as identified in Chapter 3. Information-rich cases are those from which one can learn a great deal about issues of great importance (Patton 1990:169) and excluding these service users may have reflected a narrow view of the services that are available in general practice.

Situating the research in the general practice surgeries where prescribing took place certainly placed service users in a situation where there was an inherent power imbalance. There is always a risk of bias when approaching gatekeepers and the study could have been impeded by too much reliance on gatekeepers "to make it happen". This risk of bias by using gatekeepers has been acknowledged (Chapter 3:2:1) however participants were provided who were able to articulate their experiences. These issues could not be fully controlled for but were considered to be useful pragmatic approaches to identify those in receipt of treatment within an environment that afforded ease of access and safety for the researcher and follow-on care for the service user.

Critiquing the methodological approach, it was recognized at the beginning of the work that qualitative research can be a prerequisite for understanding and responding to drug misuse and can encourage useful interventions in keeping with local practices in differing cultural settings (Rhodes 2000). Collazzi (1978) states that the success of the approach may be judged by the extent to which the approach tapped into the experience of the phenomenon, rather than the theoretical knowledge of it. Husserl's philosophy embraces the concept that the "lived state", an experience, is the basis of all knowledge however this approach is subject to criticism (Alvesson & Sköldbberg 2005). Embedding the study in the specific research genre of descriptive phenomenology proved to be too vague to support claims of reliability, validity and trustworthiness. Thus the use of a phenomenological approach coupled with an explicit reflexive methodology which incorporated bracketing interviews and polyvocality informed the study. Multiple data sources and a blended methodological approach established credibility. These qualitative approaches enabled the researcher to understand the lived experience of methadone treatment from the perspective of the service user. Using these techniques provided openness to connect with the perceptions of service users as the bracketing interviews provided a method of laying bear the preconceived ideas and prejudices on the part of the researcher. Although it was assumed at the outset that knowledge existed from those who were living the experience it was also acknowledged that knowledge was also positional in that it is generated by the researcher within a specific context and from a 'particular position' (Piantanida & Garman 2009:65). Disciplinary perspective and the identification of researcher personal bias is therefore acknowledged as a limitation of this study, as the investigator in this research has considerable experience and expertise in managing patients on a MTP. Nevertheless use of the explicit discipline of bracketing interviews at the beginning

and throughout data collection, analysis and write up demonstrated a transparency which allowed the researcher to reduce the influence of her lived experience as a practitioner on the study of service users. This parallel process of encouraging reflection provided new insights into the world of both the service provider and service user. Phenomenological inquiry and reflexive methodology supports the view that locating these presuppositions and biases is useful for clarification and vital to the process of inquiry. Polkinghorne (1989) suggests that this awareness provides protection against the imposition of the researcher's expectation of the study. The use of reflexivity, construction of texts that were credible to the experience and coherence of research conclusions reflected the complexity of the situation, and also prevented deception (Lavery 2003).

Ultimately however as the approach was novel with a methodological ambition of creative reflexivity it is the reader who must judge how the work should be interpreted.

7.4. SUGGESTED FURTHER RESEARCH

Treatment providers must set their sights beyond the safe delivery of opioid substitution treatment which, in isolation, falls short of the mark of what would be considered reasonable health care by people with other chronic health conditions (Madden *et al* 2008). Of particular importance therefore in further research is the idea of challenging our self understanding as practitioners because professionals should call into question what they already think they know and it is only with new insights perspectives and understandings that they re-forge their own ontological stance. In this regard it would be beneficial if GPs and primary care practitioners challenged their own positions and engaged in collaborative research into service users' needs and perspectives. This could be achieved initially by asking service users how best

service providers can engage with those affected by drug misuse. In this way others may have the opportunity to discern more carefully the intricacies of practice and to envisage new possibilities for how they practice (Piantanida & Garman 2009) and in so doing facilitate those they are in practice for-the service users.

The general concept of focusing on the service user could be extended to ensuring that service user engagement becomes a formal and compulsory part of the treatment protocol. The validity of this approach could be tested in a larger more comprehensive study involving service users in all GP prescribing practices in the RoI.

Specific Areas for Suggested Research could focus future studies on:

- Replicating this study with a cohort of clients outside Dublin who have limited access to treatment clinics could identify if they differ from the cohort investigated.
- Extension of this study to service users exploring aspects such as methadone diversion and buying extra.
- Understanding the dynamics of how service users are influenced by drug using peers.
- Investigating how maternity services engage with drug misusing mothers throughout pregnancy.
- Identifying the role of identity of the client in methadone maintenance programmes.

Investigating how the needs and desires of service users for control and freedom are balanced with the need to regulate the supply and prevent diversion of methadone by the service provider.

Final Bracketing Interview

I'm extremely motivated and always have been in terms of drug addiction and partly because of my role in delivering part of the substance misuse programme as you know, has been the motivation for me, educating others to see the other piece. However when you reflect on your own practice, you realise that educating anyone to the ideal is one thing. Actually putting it into practice is another...certainly in terms of my own practice I think I have been naïve, I think I have not seen the full picture, I think I have been part of a process of seeing people coming in, eh thinking that I'm dealing with the problems, thinking that I am dealing with the problem of drug misuse but in fact it is only skimming a very, very, very, fine layer.

Sean *Because you're coming across sort of like on my level you're not coming across as this like well, I'm higher than you, I'm the advanced nurse here, like you're just an addict!, which I have got before. You know like nurses saying in certain clinics, like look! I'm the nurse and their practically saying I'm above you, you know what I mean? ...so that what I say is right what you say is jibberish! that's basically the way they go on basically telling me, they're trying to tell you about the withdrawals and as I said to one or two of them- what do you know about withdrawals ? Have you ever been addicted? No, but I've read about it. I said look! I could read about anything and I'd know about this or that, **but until you experience it... then you'll know.***

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APPENDIX I

SEARCH STRATEGY

Multiple sources were accessed for the study: Primarily the National Documentation Centre provided the following resources:

- An Electronic Library of the National Documentation Centre which provided access to a compilation of electronic copies of key publications and grey literature.
- Register of research on Drug misuse in Ireland which provided information on work currently underway.
- DrugNet Newsletter and the Health Research Board Website.
- Link to Virtual Library of EMCDDA – which provided access to a pan-European information network on drugs.

OTHER SOURCES

The Annotated Bibliography of Drug Misuse in Ireland (O'Brien *et al* 2000) provided a comprehensive historical account of research and information relating to illegal drug misuse. Journal articles, grey literature, unpublished work and writings from the community and voluntary sectors are included in this work. Most of the available literature spans 1980-1999 and early 2000.

The literature review for the study was also based on a search of relevant data bases (Embase, Pubmed, Google Scholar, PsychLit). A series of search engines used and websites of relevant organizations were accessed. Researchers in the area of addiction were also contacted for information.

DATA SOURCES

ABS	Australian Bureau of Statistics
ADCA	Alcohol and Other Drugs Council of Australia
AIHW	Australian Institute of Health and Welfare
CDTL	Central Drug Treatment List
CSSA	Canadian Centre on Substance Misuse
CSO	Central Statistics Office
DMRD	Drug Misuse Research Division
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
HPSC	Health Protection Surveillance Centre
MPS	Methadone Protocol Scheme
NACD	National Advisory Committee on Drugs
NACDA	National Campaign against Drug misuse
NAPHP	National Association of Public Health Policy
NDC	National Documentation Centre on Drug misuse
NDS	National Drugs Strategy
NDTRS	National Drug Treatment Reporting System
UN	United Nations

Additional data were obtained from a range of sources:

- National Centre in HIV Epidemiology and Clinical Research
- National Crime Council
- National Drug and Alcohol Research Centre.

Background information was also obtained from the following web sites:

<http://www.aare.edu.au/04pap/sta04616.pdf>
<http://www.abs.gov.au>>
<http://www.adf.org.au>>
<http://www.aic.gov.au>>
<http://www.aihw.gov.au>>
<http://www.biomedcentral.com/1471-2296/10/25>
<http://www.britsoc.co.uk/NR/rdonlyres/E5BE55>
<http://www.calibre.ucpress.net/action/doSearch?action=runSearch&type=adva...><http://dx.doi.org/10.1111/j.1360-0443.2008.02283.x>
[http://www.ccehrn.org/EasyCEE/sys/files/Methadone Guidelines.doc](http://www.ccehrn.org/EasyCEE/sys/files/Methadone_Guidelines.doc)
<http://www.cochrane.org/reviews/en/ab002209.html>
<http://content.apa.org.ezp1.bath.ac.uk/journals/ccp/67/2/186.html>
<http://www.cmf.org.uk/literature/content.asp?context=article&id=1221>
<http://www.drugsandalcohol.ie/6875/>
<http://www.drugsandalcohol.ie/12284/>
<http://elin.lub.lu.se.ezp2.bath.ac.uk/elin?func=record&tocRecNo=5&que>
<http://www.health.gov.au>>
<http://hdr.undp.org/reports/global/1995/en>
<http://www.idpc.info>>
<http://hdl.handle.net/10147/45885>
<http://www.irishstatutebook.ie/1977/en/act/pub/0012/index.html>
<http://www.informaworld.com/smpp/title>
<http://www.informaworld.com/smpp/title~content=g779362815~db=all>
<http://www.informaworld.com/smpp/title~content=t713412630~db=all~tab=...>
<http://www.informaworld.com/smpp/title~content=t713412630~db=all>
<http://www.informaworld.com.ezp1.bath.ac.uk/smpp/title~content=g71399...>
<http://www.informaworld.com.ezp1.bath.ac.uk/smpp/title~content=t71343...>
<http://www.informaworld.com.ezp2.bath.ac.uk/smpp/content~content=a713...>
http://international.drugmisuse.gov/collaboration/guide_methadone/part
<http://www3.interscience.wiley.com.ezp1.bath.ac.uk/cgi-bin/fulltext/1...>
<http://www3.interscience.wiley.com.ezp2.bath.ac.uk/doiinfo.html>
<http://www3.interscience.wiley.com/journal/112094314/home>
<http://www.irlgov.ie/crimecouncil>>
<http://www.jstor.org.ezp1.bath.ac.uk/action/showPublisher?publisherCo...>
<http://www.jstor.org/action/showPublisher?publisherCode=ucpress>
<http://elin.lub.lu.se.ezp2.bath.ac.uk/elin?func=record&tocRecNo=23&quhttp://ovidsp.tx>

<http://elin.lub.lu.se.ezp2.bath.ac.uk/elin?func=record&resid=ae3f137a>
<http://elin.lub.lu.se.ezp2.bath.ac.uk/elin?func=record&tocRecNo=9&que>
<http://www.matuaraki.org.nz/assets/docs//APNSATS2008.pdf>
<http://www.med.unsw.edu.au/nchechr>>
<http://elin.lub.lu.se.ezp2.bath.ac.uk/elin?func=basicSearch&lang=en&q..>
<http://ndarc.med.unsw.edu.au/ndarc.nsf>>
<http:// www.nacd.ie>>
<http://www.naphp.org>>
<http://www.ncbi.nlm.nih.gov.ezp2.bath.ac.uk/entrez/query.fcgi?db=pubm...>
<http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=Search&Term=%2...>
<http://www.ndc.hrb.ie>>
<http://www.nida.nih.gov/Prevention/Prevopen.html.NICE clinical guidel...>
<http://www.ons.gov.uk/about/who-we-are/our-services/data-collection-m...>
<http://www.oireachtas.ie/ViewDoc.asp?fn=/home.asp>
<http://ovidsp.tx.ovid.com.ezp1.bath.ac.uk/spa/ovidweb.cgi?&S=EOBCFPMB...>
<http://www.phenomenologyonline.com/articles/articles.html - 31>
<https://www.researchgate.net/author/Mary+T+Blackwell>
<https://www.researchgate.net/author/Elizabeth+R+Brown>
<https://www.researchgate.net/author/Marilyn+A+Huestis>
<https://www.researchgate.net/author/Diaa+M+Shakleya>
<https://www.researchgate.net/author/Jennifer+R+Schroeder>
<http://www.researchgate.net/author/Cheryl+Harrow>
<https://www.researchgate.net/author/Martha+L+Velez>
<https://www.researchgate.net/author/Robin+Choo>
<https://www.researchgate.net/author/Lauren+M+Jansson>
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<https://www.researchgate.net/author/Hallvard+Reigstad>
<http://www.rcGP.org.uk/publications.aspx>
http://www.sciencedirect.com.ezp1.bath.ac.uk/science?_ob=ArticleURL&_
http://www.sciencedirect.com/science?_ob=PublicationURL&_tockey=%23TO...
<http://www.science direct.com.ezp1.bath.ac.uk/science>
<http://www.substancemisusepolicy.com/content/3/1/21>
<http://www.whitehousedrugPolicy.gov/>
http://en.wikipedia.org/wiki/Philip_K._Dick

<http://www.wirral.nhs.uk/uploads/documents>
[javascript:AL_get\(this, 'jour', 'Addiction.'\);](#)
[javascript:AL_get\(this, 'jour', 'BMC Public Health.'\);](#)
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[javascript: doLinkPostBack\('','ss~~AR %22Feinstein, Leon%22%7C%7Csl](#)
[javascript: doLinkPostBack\('','ss~~AR %22Maggs, Jennifer L.%22%7C%7C](#)

Personal Contact: sourced through email contact with the RACGP,
Dr Benny Monheit via email [bennym@vicnet.net.au] Date: 30/10/2007
& 4/11/2007

Medical Director, South City Clinic
Hon Senior Lecturer, Monash University, Australia

Prof Alison Ritter

Via email [a.ritter@med.unsw.edu.au] Date: 15/10/2007, 23/10/2007
who also provided the paper '*Opioid Pharmacotherapy Maintenance in
Australia –a background issues paper*' (2007) for discussion.

Ongoing sources of Information: Dr Ide Delargy, National GP Co-
Coordinator and Director ICGP substance Misuse Programme.

Programme Technical Support Mr Ben Meehan National NVivo director
(Ireland).

APPENDIX 2

LEVEL 1 & LEVEL 2 ICGP TRAINING COURSES

The educational aims of the ICGP drug misuse training programme are:

- To ensure that all participating GPs have training in the management of opiate misusers before becoming involved in treatment.
- To ensure that all GPs are supported in their attempts to provide services to drug misusers according to the best practice guidelines.
- To ensure that GPs maintain their level of knowledge and are regularly updated on current issues.(ICGP2003)

The aims and objectives of treating opiate dependant patients are stated as follows (ICGP2008:8):

To improve the physical, psychological and social health of individuals by:

- Minimising all harm associated with opiate misuse
- Reducing the health risks associated with illicit drug misuse, particularly the risk of HIV, hepatitis B and C and other blood-borne infections
- Improving the overall personal , family and social functioning of the individual
- Stopping or reducing the use of illicit or non prescribed drugs by the individual
- Facilitating and fully supporting patients in achieving a life free of drug dependence while recognising that this may not be achievable for all individuals
- Prescribing safely, which helps reduce the diversion of drugs into the illegal market

It is recommended that doctors when completing their training in general practice should have received Level 1 training and this training provides the foundation for treating stable methadone maintained patients in general practice. Stabilisation usually takes place in a health board treatment Centre but may also be offered by a suitably trained GP colleague (Level 2).

- A GP is eligible to apply for Level 2 training once the following criteria are fulfilled:
- The GP should have managed at least five patients on the MTP for a minimum of one year.
- The GP should have successfully completed an external clinical audit conducted by the ICGP.

A Level 2 GP may initiate treatment, stabilize a drug misuser and provide ongoing maintenance treatment in the primary care setting (ICGP2008).

APPENDIX 3

RESEARCH PARTICIPANT CONSENT FOR RESEARCH

TITLE OF STUDY:

Methadone in General practice: Voices of service users

CONSENT OF RESEARCH PARTICIPANT:

I _____

Give my consent to take part in an interview for the study named above.

☐ (Initial)

The researcher, Linda Latham, has explained to me the purpose of the study ☐ (initial)

I understand that I can pull out of the interview at any time and that this will not affect the care I receive from this General Practice in any way.

☐ (Initial)

I agree to this interview being tape recorded. ☐ (Initial)

DATE: _____

SIGNATURE

OF RESEARCH PARTICIPANT: _____

DATE: _____

SIGNATURE OF RESEARCHER: _____

I confirm that I have explained to
_____ the purpose and nature of this
investigation and the risks involved.

APPENDIX 4

PARTICIPANT INFORMATION SHEET

You are invited to share your experiences of treatment for heroin addiction in general practice.

What is the study about?

The study is about methadone treatment. I want to find out about your experiences of methadone treatment in general practice. This study is about **your** views on how addiction treatment is delivered **to you** in general practice.

Who is doing the study?

The research is being conducted by Linda Latham, who is an Advanced Nurse Practitioner in Primary Care at the Liberties Primary Care Centre in Dublin. Linda is conducting the research as part of a higher professional degree (Doctorate) at the University of Bath in England. Linda is the researcher responsible for carrying out the interviews and recording / analyzing the information contained in each interview and her work is being conducted under the supervision of colleagues at the University of Bath and University College Dublin.

Who can take part in the study?

People who attend General Practice for methadone treatment. A maximum of 20- 30 people will be interviewed in different practices in Dublin.

Why have I been chosen?

You have been suggested by your GP who is involved in your care because you are receiving methadone.

What will I have to do?

The doctor or practice nurse will explain the study to you. If you are willing to take part in this study, then I [Linda Latham] will arrange to have a private interview with you. Each interview will take approximately

one hour and will be situated in your own doctor's surgery. During the interview, you will be asked about your experiences of methadone treatment, the services available to you and your views on if or how these services can be improved. There will also be time to comment on any other issues you may feel are important.

What will happen to the information collected from me?

The details of the interview will be recorded on cassette tape. Only the researcher and transcriber (the person who will help me to listen to the interview and type it) will listen to this tape. Your name will not be written on the tape, instead I will write on a code number.

Personal information such as your name, address or date of birth will not be stored. Only the researcher and supervisory team will have access to the information collected. The anonymised information will be stored as an electronic computer file on a secure password-protected computer at the Liberties Primary Care Centre five years after the study's findings have been reported.

Might any harm result for me from this study?

The risks of any harm resulting to you from the interviews are minimal. It is important that you understand that the interview is being conducted for research purposes and your GP or practice nurse or counsellor will not be informed of what you say in your interview and your treatment will not be affected by what you say. Sometimes speaking with a researcher about your experiences of addiction and methadone might raise some issues that need to be discussed with a health professional. Therefore it is advisable that should the interview raise any concerns for you an appointment with your doctor should be arranged. Likewise should anything arise during the course of the interview which would be considered a serious potential risk for you or to protect the rights of another, I will in those circumstances be obliged to discuss this with you and to inform your doctor.

What are the benefits of the study?

You will not likely benefit from being a participant. I hope and expect that the outcomes of the research made possible by the study will be of benefit to those involved in treatment for drug addiction in general practice.

Will I receive any payment for taking part in the study?

No, payments for taking part in the study are not offered.

What is the procedure should I wish to withdraw from the study?

You may at any time pull out from the study as it is voluntary.

Your views are important but you do not have to take part. Should you decide to pull out from the study after the interview is over, please contact me [Linda] at [7085701]

When is the study being conducted?

The study is starting in September 2008 and is finishing in September 2010.

When are the results available?

The full results and implications of this study are unlikely to be unknown until September 2010. You can have full access to the results of this study once completed. No identifying information will link your interview to you as data will be collected anonymously. It is possible that information about the study might be published in scientific journals. However, no information that might identify you will appear in these publications. Any quotes used will be anonymised.

What if I have any questions now or at any time during the study?

Should you wish to discuss any aspect of this study now or at any stage, you can contact me [Linda Latham] at [7085701].

Thank you for taking the time to consider this study.

APPENDIX 5

LETTERS TO GENERAL PRACTITIONERS & STEP BY STEP GUIDE

Dear Dr,

I am undertaking a research project called: ***Methadone in General Practice: Voices of Service Users***. I would like to interview some of your patients about their experiences in treatment, the services available to them and if or how they feel these services need to be improved. With your consent and co-operation I will interview patients who you would consider suitable for this study. The study design proposes to purposefully select participants who have been exposed to diverse life experiences and are willing to participate in the study. The sample is not intended to be representative of the general practice population. I am more interested in understanding in-depth the experiences and perspectives of methadone maintenance from the viewpoint of the service user. I do not wish to generalize these experiences to a larger population. A small sample of 3-4 patients would be necessary only as I will be visiting other general practices in the city. I would be very grateful for your assistance with this study. I will ensure confidentiality and anonymity of both the practice and patients involved. I will follow up this letter with a telephone call to ask whether you would like to be involved.

Yours Sincerely,

Linda Latham

WHAT DOES THIS RESEARCH MEAN TO THE PRACTICE?

Your practice has been chosen as you have previously granted me permission to conduct a study with you researching the perceptions and experiences of your practice nurse in relation to patients receiving methadone.

Realistically any research carried out in your practice will cause some disruption although every effort will be made to minimize this. Potentially a member of the practice staff (e.g. Practice Nurse) could be designated as the main contact for the study to ensure effective communication. Patient recruitment can be carried out with the help of the practice nurse. As the overall clinical responsibility is yours, should anything arise during the course of the interview which would be considered a serious potential risk to your patient or to protect the rights of another for e.g. threat of suicide or child misuse, I will inform the patient that I must alert you.

The use of surgery space will be necessary for one hour when it is deemed convenient for the practice. The service user may have to be interviewed in the afternoon after methadone has been consumed to avoid any withdrawal effect.

The findings from the study may have several outcomes. Whilst the findings may provide evidence of high quality care in general practice for service users, equally, dissatisfaction with some aspects of the Methadone Treatment Protocol may be highlighted. My own practice will also be researched by an independent researcher. These findings could be considered an important aspect of patient management and could influence the future delivery of care. The results will be anonymised so no practice will be identifiable

I have received ethical approval from the ICGP and University of Bath for the study.

STEP BY STEP GUIDE FOR CLIENT RECRUITMENT

HOW WILL POTENTIAL PARTICIPANTS BE IDENTIFIED?

- A) IDENTIFY A CLIENT THAT ATTENDS YOUR PRACTICE FOR METHADONE PRESCRIPTIONS.
- B) CONSIDER WHETHER THIS CLIENT WOULD BE WILLING TO PARTICIPATE IN AN INTERVIEW.
- C) WOULD HE OR SHE BE LIKELY TO TURN UP FOR THE INTERVIEW?

* PLEASE DO NOT ASK A CLIENT WHOSE ABILITY TO PROVIDE INFORMED CONSENT TO PARTICIPATE IN THIS STUDY IS COMPROMISED BY ACUTE MENTAL OR PHYSICAL ILLNESS.*

HOW WILL THEY BE APPROACHED REGARDING THEIR POTENTIAL PARTICIPATION IN THE STUDY?

- a) ASK THEM IF THEY WOULD BE WILLING TO BE INVOLVED
- b) GIVE THEM THE PARTICIPATION LEAFLET
- c) ASK THEM IF I CAN CONTACT THEM BY PHONE TO ARRANGE A TIME IN THE SURGERY FOR THE INTERVIEW.
- d) PLEASE GET A CURRENT PHONE NUMBER.

HOW WILL INFORMED CONSENT TO PARTICIPATE IN THE STUDY BE OBTAINED?
I WILL MEET WITH THE INTERVIEWEE AND OBTAIN CONSENT.

SHOULD YOU HAVE ANY QUERIES RE THIS PROCESS PLEASE RING ME (087 6500775)

AGENT NOMINATION FORM

Practice Name _____

As a General Practitioner representing the practice named above, I hereby nominate (*Linda Latham*) as an agent of this practice for the purposes of the Data Protection Acts 1988 and 2003, for the duration of the practice's involvement in the study (*Methadone in General Practice : Voices of Service Users*).

As an agent of the practice, (*Linda*) will be bound by the normal procedures governing patient confidentiality in this practice. Information about individual patients will be treated confidentially and will be used solely for the purpose of the research study.

(*Linda*) will remove personal identifiers from the data to ensure that only anonymised data is disclosed from the practice to the study.

GP SIGNATURE : _____ **DATE:** _____

AGENT SIGNATURE: _____ **DATE:** _____

AGENT NAME _____

PRACTICE CONFIDENTIALITY AGREEMENT

PRACTICE NAME:

As a researcher working with the study (*Methadone in General Practice: Voices of Service Users*) I agree to be bound by the normal procedures governing patient confidentiality in this practice. Information about individual patients will be treated confidentially and will be used solely for the purpose of the research study.

RESEARCHER SIGNATURE: _____

DATE: _____

WITNESSED BY (MEMBER OF PRACTICE STAFF):

LETTER POST INTERVIEWS

PRIVATE AND CONFIDENTIAL

Dear Dr's,

Thank you for allowing me to visit your surgery. It was a pleasure to visit and all the staff made things so easy for me to interview your patients for the purposes of my research.

For your information I interviewed your patients named below.

All voluntarily consented to the process and no incentives were offered prior to the interview. I have a small grant from the ICGP and part of this enabled a 20 euro voucher for Dunnes stores to be given to each interviewee once the interview was completed. Each respondent's verbatim interview will be individually posted to them if they wish and

any follow up after that will be by phone to ensure that I have accurately transcribed their 'voices'. I hope that each respondent found the process of 'telling their story' in some sense therapeutic but if any harm has resulted from this reflection I would appreciate you letting me know. As you know all details of the interview are confidential and the results of the collated data will be anonymised and made available to you when the study is completed.

Many thanks again for your help and should you wish to discuss anything with me about the study my phone number is 087 6500775.

Yours Sincerely,

Linda Latham

APPENDIX 6

INTERVIEW TOPIC GUIDE

Thank you for agreeing to take part in this interview. As you know from the written consent that you signed, this interview is confidential, and your views will be treated anonymously.

TOPIC 1 GENERAL PRACTICE

- I'm interested in getting your views on what it's like attending here? (GP practice- for methadone maintenance)
- What are your views on general practice?
- Have you had a lot of dealings with GPs (before you started on methadone?)
- How much have you used GP services for your health care? (E.g. women's health, pregnancy? Men's health etc?)

TOPIC 2 METHADONE MAINTENANCE-(THE ROLE OF METHADONE AS A TREATMENT FOR DRUG ADDICTION)

- Do you think /feel you have a drug problem?
- How does it make you feel to be attending a GP for that problem /for methadone
- Do you feel listened to? -Are your views important?
- Do you feel that methadone has helped you? - What does it help you with?
- What more could be done to help?

TOPIC 3 PARTNERSHIP /INVOLVEMENT IN CARE

- If you are not happy with some aspect of how your treatment is going how able are you to voice your concerns?
- Have you ever had an experience that you negotiated a change in treatment? - can you tell me about that?
- What are your future plans?

TOPIC 4 PROTOCOL /INFLUENCING FACTORS

- What do you understand by the term methadone protocol?(Examples Urine testing/ take away doses/attending the GP every week)
- From your experience are there any aspects of this protocol that you would change?
- What do you feel influences GPs in taking on patients who are on methadone?

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?

- Thank you for taking part. If you wish I will give you back the transcript of your interview so you can check whether I have accurately reflected your views.

APPENDIX 7

DESCRIPTIVE STATISTICS

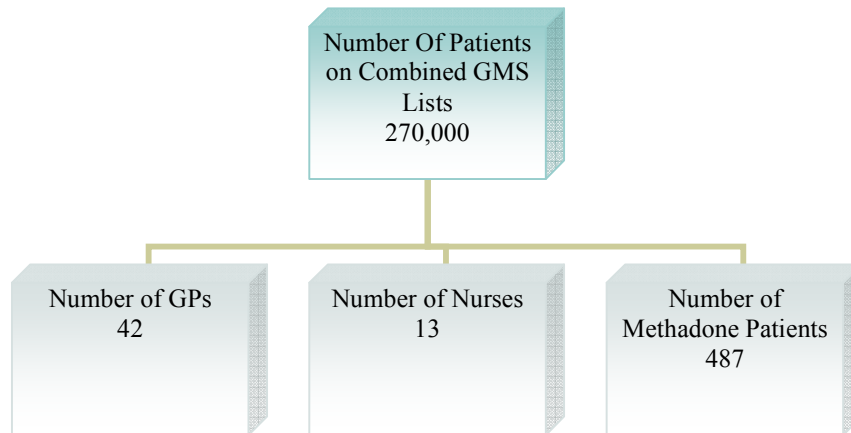



Figure 5 Context of the Study.

This table denotes the number of GPs & practice nurses employed in the combined practices. It also shows the approximate numbers of patients listed on the combined General Medical Scheme lists and number of methadone patients registered with their practice.

The central drug treatment list (CDTL) denotes those patients registered on maintenance in the Republic in the period April 2009.

			
Central Treatment List Summary Report for period 01 April to 30 April 2009			
CLINICS			
	Total Patients during period	Total Patients at End of Period	New (1st time patient on CTL)
HSE Dublin Mid Leinster	2430	2385	19
HSE Dublin North East	2038	1976	22
HSE West	225	219	9
HSE South	153	150	9
Prisons	621	490	19
Drug Treatment CENTRE Board	541	523	3
Totals	6008	5743	81
GENERAL PRACTITIONERS			
	Total Patients during period	Total Patients at End of Period	New (1st time patient on CTL)
HSE Dublin Mid Leinster	1874	1850	6
HSE Dublin North East	1043	1030	4
HSE West	147	146	0
HSE South	57	57	0
Totals	3121	3083	10
Grand Totals	9129	8826	91
Actual Patients Attending	8984		

PROFILE OF THE PARTICIPANTS – DESCRIPTIVE STATISTICS

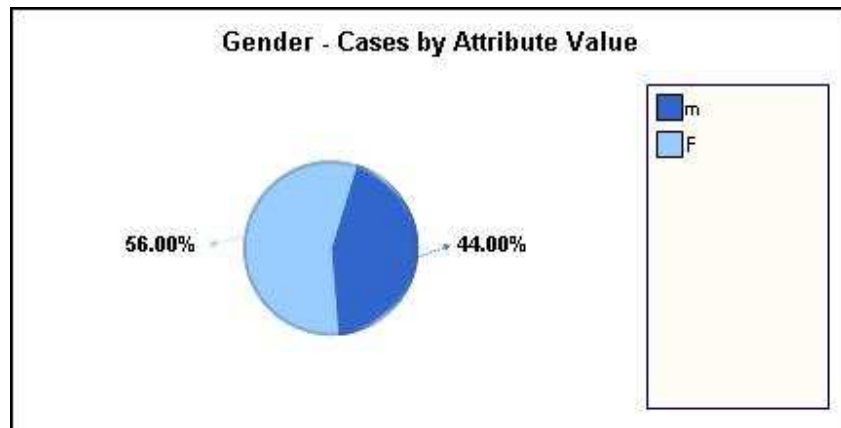


Table 1 Gender Female =14 Male =11

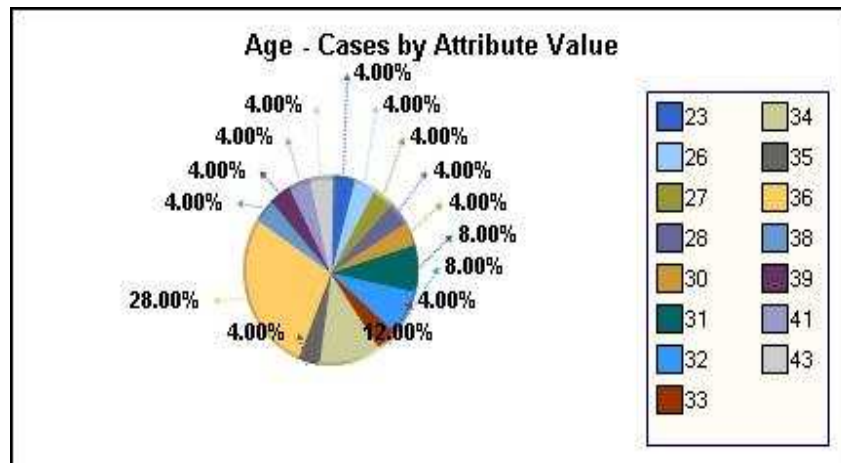


Table 2 Age Range =23-43

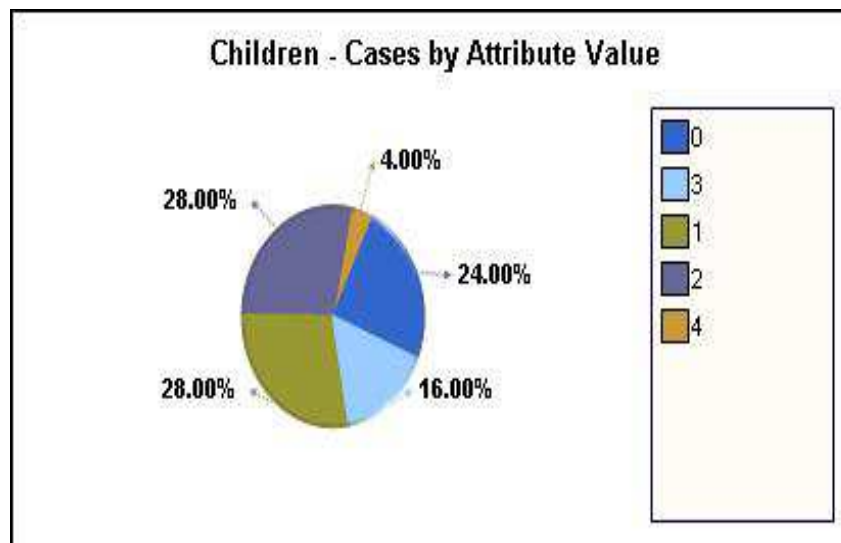


Table 3 Number of Children (37) (Majority Had 2 Children)-6 had no children

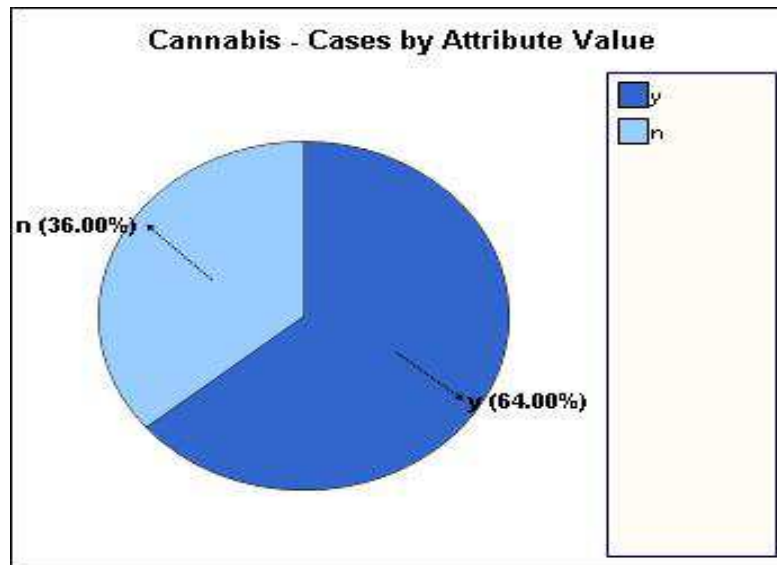


Table 4 Current Drug Taking History

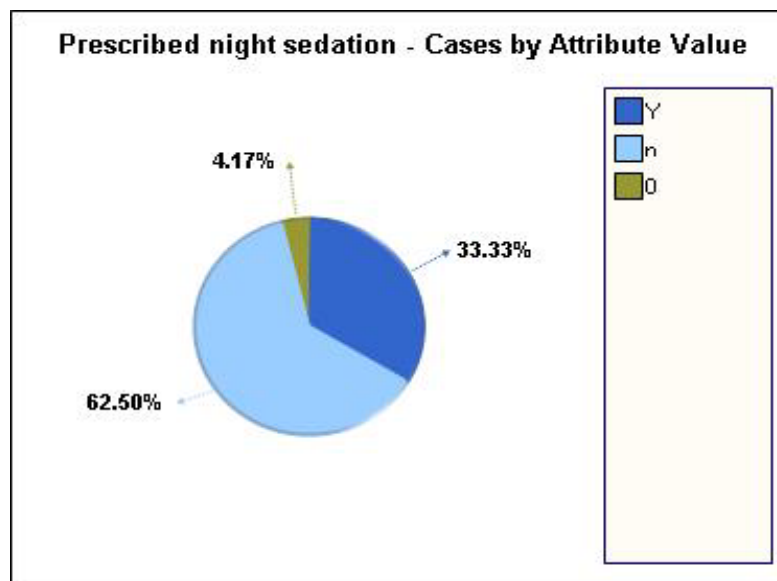


Table 5 Prescription of Night Sedation 8 prescribed by GP

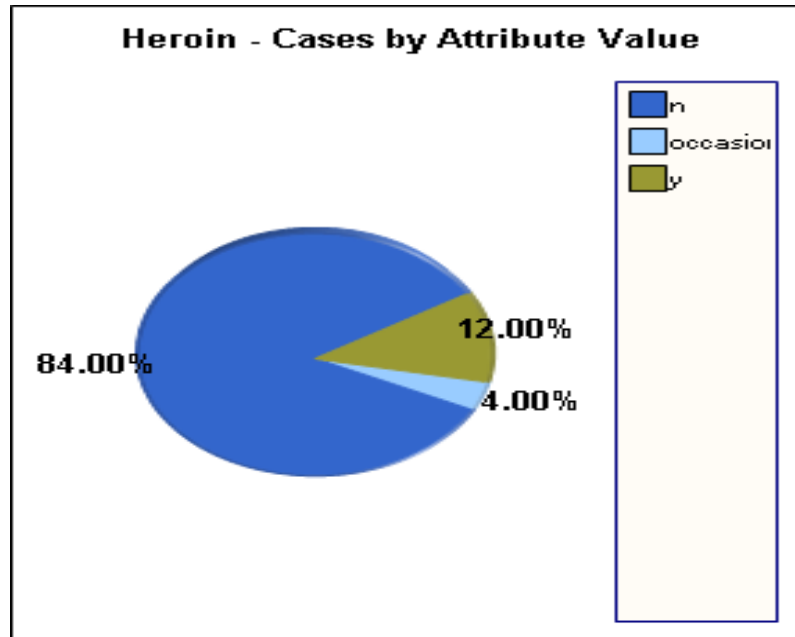


Table 6 Currently Taking Heroin

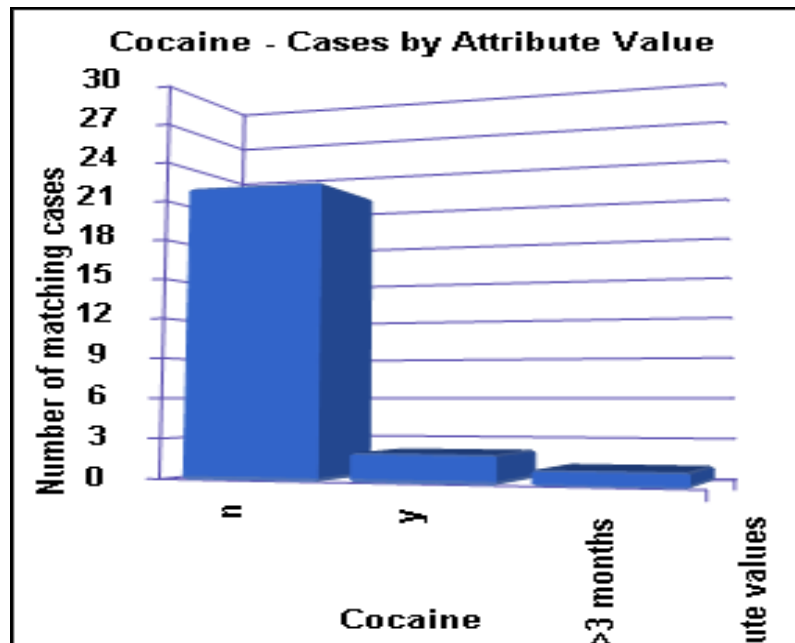


Table 7 Currently Taking Cocaine

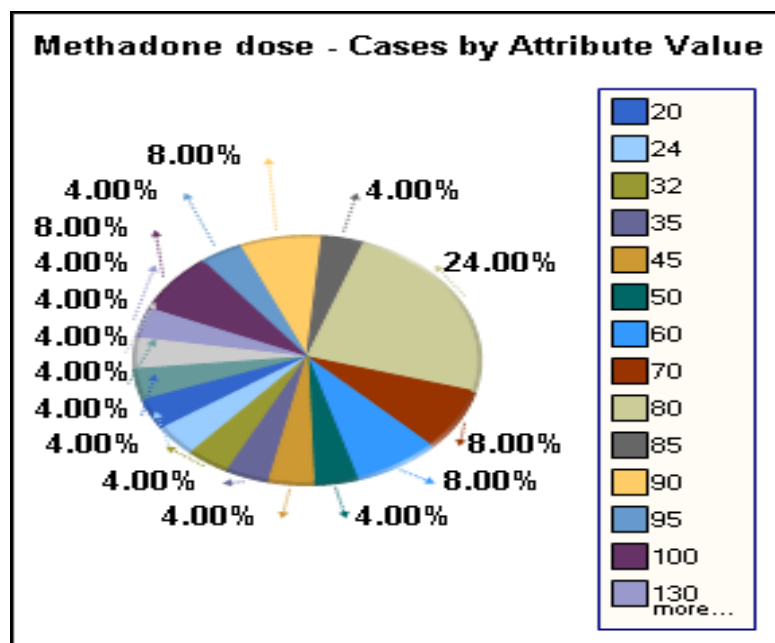


Table 8 Current Methadone Dosage Range 20-150 mgs

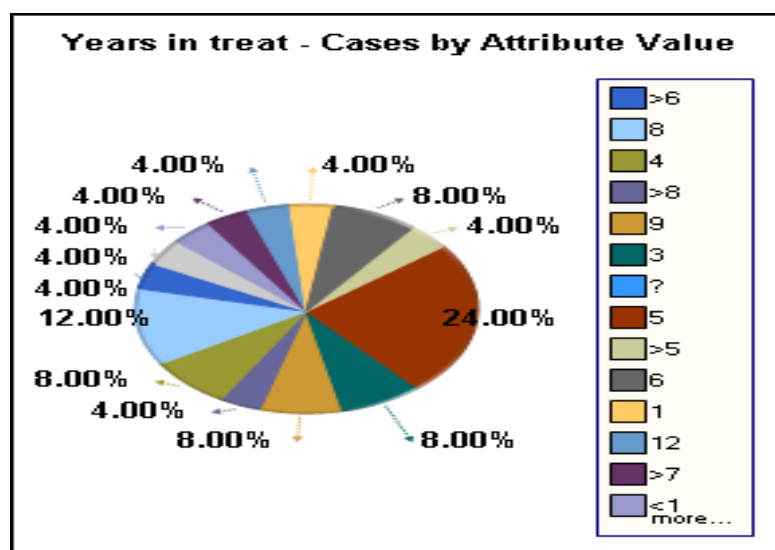


Table 9 Length of Time in Treatment

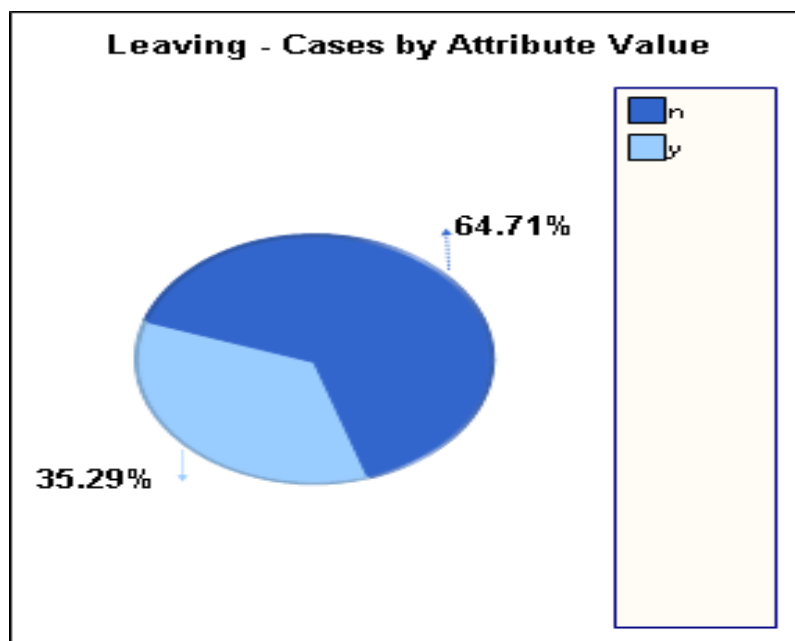


Table 10 Educational Level Achieved – Leaving Certificate =6 Junior Cert=18

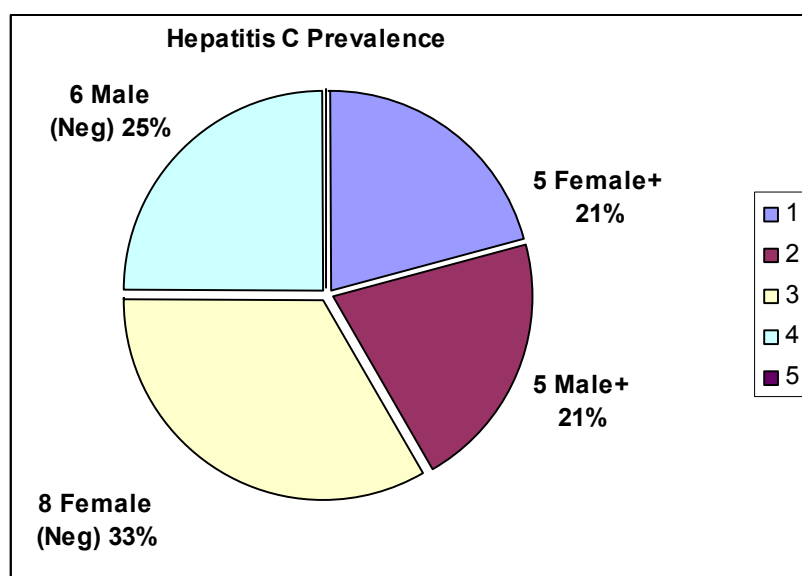


Table 11 Prevalence of HCV

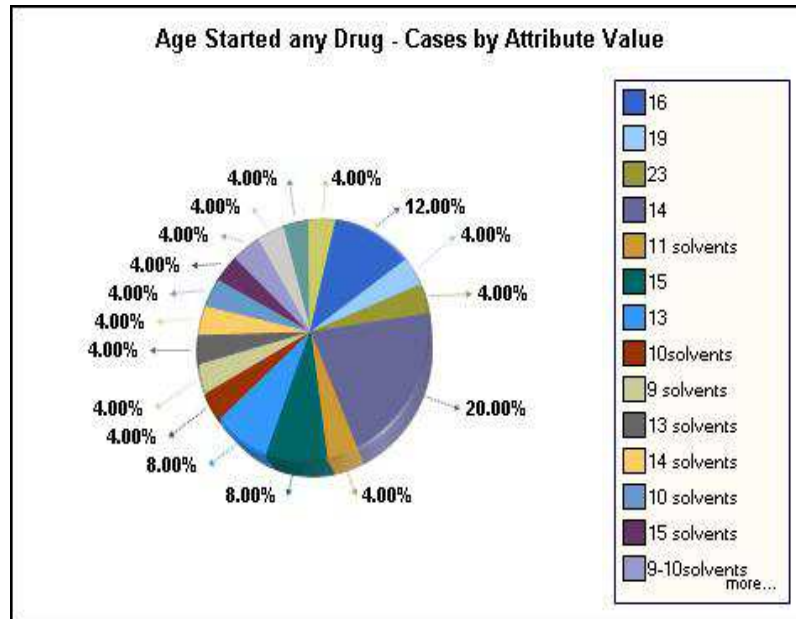


Table 12 Age started any drug

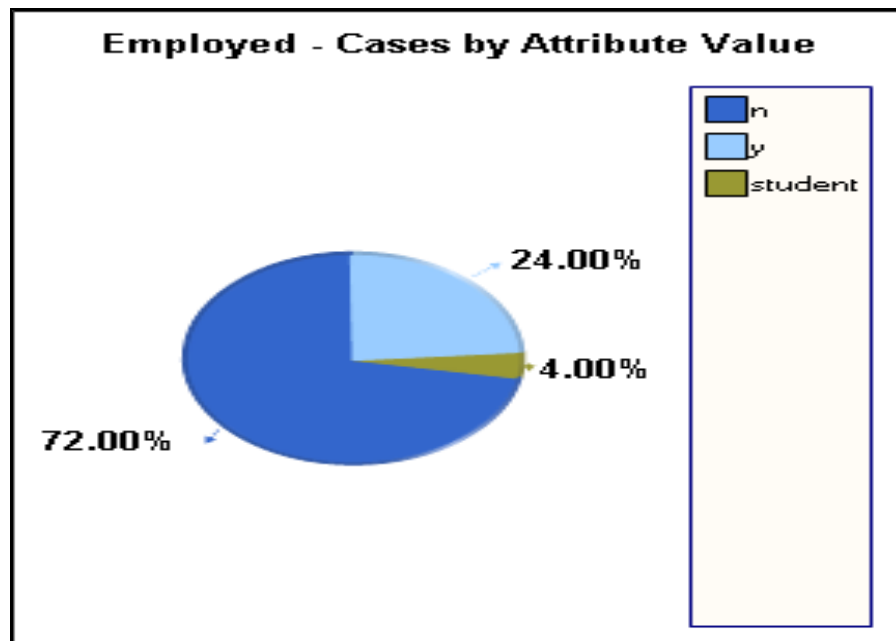


Table 13 Employment Status

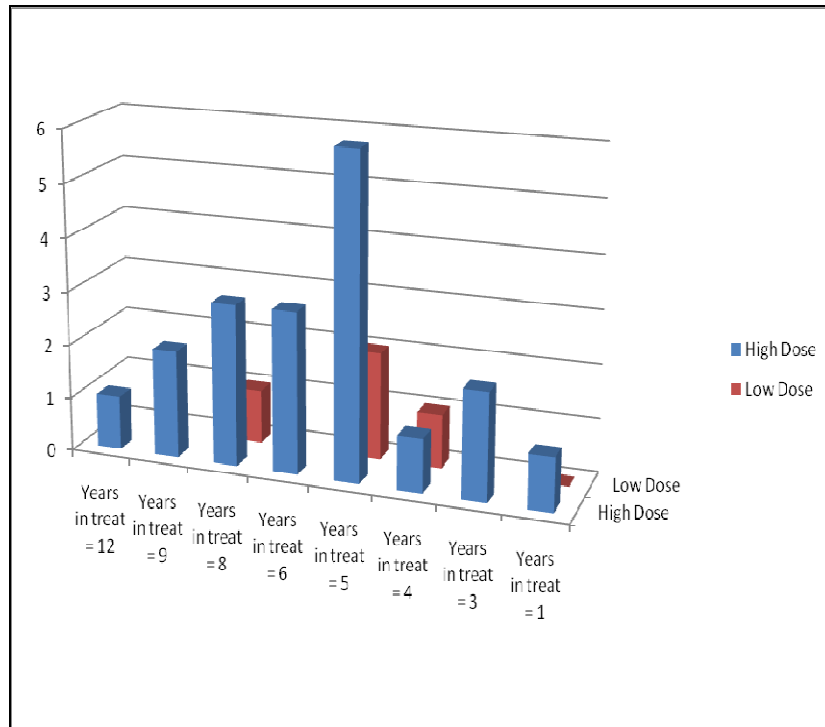


Table 14 Years in treatment and methadone dosage

Low Dose Defined as 40mgs or lower

High Dose Defined as 45mgs or higher

Whereas some participants ran against the trend (low years/ high dose or high years/ low dose) this graph clearly shows a consistent pattern in the data. That is, a clear relationship between the length of time in treatment and the dosage of methadone with patients in treatment longer being prescribed higher doses.

TEMPLATE FOR BIOGRAPHICAL DETAILS

Informant Number	
Service Users Group	
Age	
Gender	
Status/Living arrangements	
Age commenced drug misuse	
Other Drugs Currently Used A)Cannabis B)Cocaine C)Heroin D)Hash E)Benzo F)Other	
Current Employment	
Educational Standard	
Viral Status Hep C/B/HIV	
Years in Current Treatment	
Current Methadone dose	
Level One/Level Two	

APPENDIX 8

REFLECTION

This study has forced me to engage in a reflective process in order to re-examine my biases. Etherington (2006) explains that a '*bias that we are aware of, a passion deeply felt, may be the entree into the experience we choose to study*'.

The motivating factor for the study, from my perspective, was the ongoing problematic opiate misuse in the Republic Of Ireland which has been concentrated in the Dublin area in localities with high levels of social and economic disadvantage. The inner city of Dublin is one such area where I have worked and have first hand experience of what I describe as the 'chaotic situation' of drug misuse prior to and since the inception of the Methadone Treatment Protocol in 1998.

Past experiences of dealing with drug misusing clients may have influenced me to be in favour of the implementation of methadone maintenance. I have been present when mothers have begged on their hands and knees for treatment for their children and their frustration was coupled with the frustration I felt with my inability to provide help.

The advent of the MTP provided a way of responding and reacting to the needs of the community. Many drug misusers were dying as a result of HIV in the 1980's. I had worked as a casualty nurse seeing patients attending accident and emergency feigning renal colic in order to obtain an injection of cyclimorph. I remember vividly the day I was asked by a doctor to give an injection of normal saline to a drug misuser and to pretend it was pethidine. I inherently felt that this was the wrong way to treat drug misuse yet I knew no better either experientially or academically at that time.

I moved from the hospital into general practice in the inner city and was immediately faced with an epidemic of uncontrolled heroin misuse. My GP employer (husband) felt duty bound to provide treatment for the

community and with a small amount of committed doctors joined the early drugs task force members who lobbied the government for the introduction of the MTP.

The protocol has been in operation for 11 years and almost by default as I had gained experience from the early patients on methadone I became involved in the training of GPs and practice nurses. Since that time I set up a shared care system whereby GPs and practice nurses shared the care between them for their drug misusing clients. I am passionate about caring for drug misusers but acknowledge that the MTP provides only a partial answer to the treatment of the complexities associated with addiction. The reality of being addicted to this treatment modality creates in me certain unease at the very long term prospect of what many methadone clients call the 'liquid handcuffs of treatment'.

I have equally been committed on both a professional and voluntary basis in dealing with clients who are associated with faith based organizations whose approach to rehabilitation treatment is fundamentally different to methadone maintenance. This treatment requires total abstinence with no recourse to methadone. In many ways the ethos of treatment can be seen as the antithesis to long term opiate substitution. Both approaches work if tailored individually.

My responses in the bracketing interviews to the challenges of being a practitioner/researcher illuminate a personal progression through the study as indeed I have lived the study, both in my daily work environment and as a researcher.

The most intensely demanding work of the study has been this movement from the practical daily working with drug misusers-that is from the concrete, to the somewhat abstract act of collating findings and analysis. Yet the challenge was to remain immersed in the subject. I have recognized that I moved from the idiosyncratic to the universal and from the situational to the conceptual in my approach.

The study has changed me, I had assumed that I was experienced in managing drug misusing clients but now I find myself more tolerant of the diversity of patients' wishes – the lifer, the maintainer and the reducer. Initially, in my study, I felt I knew what I was going to find out. As I listened further I realized how far my professionalism was clouding my reasoning. I had to return to my pre-training days and view others with a naive lens. It was only then that insight came. I learned to listen to the voices of those I had consulted with day in day out. I really listened and then grew to understand my own worldview more clearly. Furthermore I learned to listen to my own inner voice and that again was as a result of being instructed by those who told me of their experiences. As a result of listening to these service users I realize that once again, expertly, they have gently instructed me in how to care for them effectively.

This study has shown me the resilience of the people of the inner city of Dublin, renewed my commitment to work with them and challenged me to teach others what I learned on my dissertation journey.

APPENDIX 9

SCREEN DUMP I CREATION OF FREE NODES

The screenshot shows the NVivo interface with the 'Free Nodes' list. The list contains the following data:

Name	S	References	Created On	Created By	Modified On	Modified By
An Addict still	1	19	26/10/2008 1	LL	03/04/2009 1	LL
Benefits of General Practice	2	105	25/10/2008 1	LL	03/04/2009 1	LL
Buying extra	2	88	26/10/2008 1	LL	17/03/2009 1	LL
Chemist	2	98	25/10/2008 1	LL	13/03/2009 1	LL
Clinic	2	84	25/10/2008 1	LL	17/03/2009 1	LL
Confidentiality	2	73	25/10/2008 1	LL	03/04/2009 1	LL
Control over treatment	1	51	26/10/2008 1	LL	17/03/2009 1	LL
Counselling	1	53	26/10/2008 2	LL	17/03/2009 1	LL
criminal activity and identit	4	21	22/11/2008 1	LL	30/01/2009 1	LL
Deaths	1	33	26/10/2008 0	LL	11/02/2009 2	LL
Education about methadon	1	26	27/10/2008 1	LL	03/02/2009 1	LL
Effect on Children	1	95	26/10/2008 0	LL	01/02/2009 1	LL
Family support	1	38	26/10/2008 0	LL	17/03/2009 1	LL
Fear of being cut off from t	7	16	26/10/2008 1	LL	23/01/2009 1	LL
Future Plans	2	54	25/10/2008 1	LL	17/03/2009 1	LL
Inequality	3	12	25/10/2008 1	LL	30/01/2009 1	LL
Influencing factors for Gp's	2	66	26/10/2008 0	LL	17/03/2009 1	LL

SCREEN DUMP 2 CREATION OF FREE NODES

The screenshot shows the NVivo interface with the 'Free Nodes' list. The list contains the following data:

Name	S	References	Created On	Created By	Modified On	Modified By
Influencing factors for Gp's	2	66	26/10/2008 09	LL	17/03/2009 1	LL
Loitering	1	22	25/10/2008 12	LL	01/02/2009 1	LL
Looking after other drug mis	1	35	25/10/2008 12	LL	01/02/2009 1	LL
Methadone as a drug	2	133	25/10/2008 12	LL	17/03/2009 1	LL
Methadone Protocol	2	150	25/10/2008 12	LL	17/03/2009 1	LL
Normality	2	56	25/10/2008 16	LL	03/04/2009 1	LL
Other things going on	1	25	26/10/2008 21	LL	01/02/2009 1	LL
Post natal issues	9	35	26/10/2008 09	LL	01/02/2009 1	LL
pregnancy	9	44	05/11/2008 19	LL	01/02/2009 1	LL
Reduction Strategies	2	63	26/10/2008 09	LL	17/03/2009 1	LL
Relationship with GP's	2	181	25/10/2008 12	LL	17/03/2009 1	LL
Rogue Doctors	1	66	26/10/2008 09	LL	17/03/2009 1	LL
Services	2	124	25/10/2008 12	LL	17/03/2009 1	LL
Stability	2	66	25/10/2008 12	LL	17/03/2009 1	LL
Stigma	1	41	25/10/2008 12	LL	17/03/2009 1	LL
Urban Myths	1	42	25/10/2008 12	LL	17/03/2009 1	LL
URINALYSIS	2	96	26/10/2008 09	LL	13/03/2009 1	LL
Withdrawal	1	66	25/10/2008 12	LL	17/03/2009 1	LL

TABLE 1 – CODING HIERARCHY

Theme	Sub themes	Rules for Inclusion & Proposition Statements					
These synthesized statements were collected and organized into further clusters of themes. The individual themes were then clustered to produce a further reduction into general themes that were common to all the subjects' transcripts. <u>THEME 1 -SERVICE USERS' EXPERIENCE OF ATTENDING GENERAL PRACTICE</u>	0		0				
	Name	Description	Memo Link	Sources	References		
		Place to reduce/Be listened to- Relationship with GP / have your general health checked/be respected & less stigma /confidential /swift access/ less loitering		0	0		
	Type	Name	Description	Memo Link	Sources	References	
	Tree Node	Benefits of General Practice	This node refers to the co-researchers references to the good aspects of General Practice		23	106	
		Type	Name	Description	Memo Link	Sources	References
		Tree Node	A Place to Develop Relationships	Good Bad & complicated – both Developed	Yes	25	182
		Type	Name	Description	Memo Link	Sources	References
		Tree Node	Bad	This node denotes the relationships in general practice which were not beneficial	Yes	12	33
		Tree Node	Good	This node	Yes	25	100

Theme	Sub themes	Rules for Inclusion & Proposition Statements					
				describes good relationships			
		Tree Node	Men talking about relationships	This node denotes the descriptions men attributed to relationships	Yes	11	74
		Tree Node	Women talking about relationships	This node refers to the descriptive statements women made about relationships	Yes	14	108
	Tree Node	A Place to Reduce	This node is the merged node of 'control over treatment and reduction strategies a negotiated relationship of client in control	Yes	24	112	
		Type	Name	Description	Memo Link	Sources	References
		Tree Node	Negotiating a reduction- no its my decision because I want to!	This node refers to the participants' control over methadone reduction - most are well able to negotiate but there is a feeling that in some instances it can be pressure from the doctor/nurse to reduce which is not welcomed	Yes	21	71
		Tree Node	Negotiating increase- I negotiated that real quick	This node refers to what the participants felt about increasing	Yes	11	20

Theme	Sub themes	Rules for Inclusion & Proposition Statements					
				their dosage and what level of negotiation was required to achieve this - most did not want to go up and saw it as a failure			
	Tree Node	A Place to 'Sort Things Out'	This node refers to the participants' references to the services provided in their own GP Practice and the services they choose to avail of or not	Yes	24	127	
		Type	Name	Description	Memo Link	Sources	References
	Tree Node		What You Can 'Get Sorted'	This node describes what services are available to the service user in general practice which they feel are beneficial to them		23	98
	Tree Node		When you Can 'Get Sorted'	This node denotes the availability of these services		15	34
	Tree Node		Women talking about services	This node describes how women define what services are beneficial to them		14	71
	Tree Node	A Place which is Confidential	This node will contain references by co- researchers to confidentiality	Yes	23	86	

Theme	Sub themes	Rules for Inclusion & Proposition Statements					
Tree Node			within the practice which is possible as there is less loitering around the practice than in clinics- merged nodes				
	Tree Node	Comparison with Clinics	All references by co- researchers to the 'Clinic' In a clinic they' treat you all the same' in comparison to General practice	Yes	22	84	
		Type	Name	Description	Memo Link	Sources	References
		Tree Node	A Place to be Treated as an Individual	This node refers to the participants views when general practice is compared to treatment clinics		15	31
		Tree Node	Not a place to get clean- cause its all around you isn't it you know?	This node refers to the participants' views of getting clean - comparing the clinic to general practice		18	36
	Negative Aspects- Lack of Counselling	This node describes counselling and the lack of defined counselling available in General practice	Yes	0	0		
	Type	Name	Description	Memo Link	Sources	References	
	Tree Node	What you Can't 'Get Sorted'	This node refers to the lack of services		19	59	

Theme	Sub themes	Rules for Inclusion & Proposition Statements				
THEME 2 -THE SIGNIFICANCE OF METHADONE FOR THE SERVICE USER		available to the service user				
		Identity/normality/ stability/ Economic benefits/ Education/ crime reduction/ virus prevention	0	0		
	Type	Name	Description	Memo Link	Sources	References
	Tree Node	Buying Extra	This node highlights the buying of extra methadone on the street and selling - likened to 'writing a blank cheque'	Yes	23	91
	Tree Node	Lack of Education & Urban myths	This node merged 'education' and 'urban myths' This refers to the desire to learn more about methadone and the lack of educational opportunities available to discuss the effects of the drug resulting in urban myths about methadone	Yes	15	68
	Tree Node	Lifers/ Maintainers/ Reducers	This node refers to the co-researchers references to their plans for recovery but also identifies, lifers, maintainers and reducers so it will be merged into the sub theme with those three names	Yes	23	54
	Tree Node	Methadone as a drug	This node refers to the co-researchers references to methadone as a treatment for heroin addiction	Yes	22	131
	Type	Name	Description	Memo Link	Sources	References
	Tree Node	Benefits Health	Methadone benefits health	Yes	15	24
	Tree Node	Daily requirement not every 2 hours	Benefits of daily dosing		4	6
	Tree Node	Feelings About the Drug Itself	Feelings about substitution with		4	7

Theme	Sub themes	Rules for Inclusion & Proposition Statements				
Tree Node			methadone			
	Tree Node	Happy the way things are	Methadone identity defined by maintenance dose	Yes	7	13
	Tree Node	I'm a lifer	Methadone identity defined by length of time in treatment	Yes	10	29
	Tree Node	Prevents Crime	Methadone prevents pursuit of money /crime		7	21
	Tree Node	Reducer	Methadone identity defined by reduction in dosage	Yes	13	28
	Tree Node	Virus Protection	Service users views about virus protection		3	6
	Normality & Stability	This merging was done as the participants described normality and stability as two aspects of the benefits of methadone	Yes	25	120	
	Type	Name	Description	Memo Link	Sources	References
THEME 3 -SERVICE USERS' UNDERSTANDING OF THE MTP	Tree Node	Its like a security blanket	What methadone provides in personal terms		24	76
		Rogue doctors /Chemist / Urinalysis /Knowing the system /what influences a GP to look after drug misusers	0	0		
Type	Name	Description	Memo Link	Sources	References	
Tree Node	Fear of Being Cut Off	This node describes the fear the client has about being thrown off the MTP and the inequalities of how the system		10	31	

Theme	Sub themes	Rules for Inclusion & Proposition Statements				
Tree Node	Influencing Factors for GP's-	is maintained This node describes how the service users understood what motivates GP's to take on patients for methadone maintenance	23	66		
	Looking after Other Drug Misusers-	This node refers to the co-researchers references to other drug misusers and how they feel they should look after them as part of the expectations of their own sub culture	11	35		
	Methadone Protocol-	This node refers to the co-researchers references to what they understand by the MTP	25	140		
Tree Node	Type	Name	Description	Memo Link	Sources	References
	Tree Node	Knowing the Rules	This node refers to the service users knowledge of the rules of the MTP		19	40
	Tree Node	What the MTP Means	This node refers to the knowledge service users hold about the MTP		12	26
	Tree Node	Working the System	This node contains the references of how service users circumvent the rules of the MTP		14	26
Tree Node	Rogue Doctors	This node refers to experiences with rogue doctors which has now influenced their current perception of the programme both positively and negatively	21	75		

Theme	Sub themes	Rules for Inclusion & Proposition Statements					
THEME 4 -THE EXPERIENCE OF ADDICTION AND IT'S EFFECT ON FAMILIES	Tree Node	Significance of the Chemist	This node refers to the co-researchers references to the dispensing of methadone at the pharmacy, lack of confidentiality in most pharmacies , and how some 'get away' with collecting methadone without supervision	25	100		
	Tree Node	Urinalysis	This node refers to all the issues of providing a sample, bogey urines and supervision	26	99		
		family dysfunction, effect on children/stigma / other things going on	0	0			
	Type	Name	Description	Memo Link	Sources	References	
	Tree Node	Effects on Children-	This node describes the effect of drug addiction/ methadone maintenance on children		19	96	
		Type	Name	Description	Memo Link	Sources	References
		Tree Node	Length of time in treatment			0	0
	Tree Node	Men talking about effects on family	Men's' descriptions of their family and children and what they tell them		7	29	
	Tree Node	Women talking about effects on family	This node describes women's' feeling about methadone and what they tell their children		12	67	
Tree Node	Identity	This node describes what a client feels about themselves in relation to addiction and		23	79		

Theme	Sub themes	Rules for Inclusion & Proposition Statements				
Tree Node	Pregnancy and Post Natal Effects	stigma and identity in their community This node refers to the experiences of methadone users while pregnant, during delivery and the post partum period	11	80		
	Type	Name	Description	Memo Link	Sources	References
	Tree Node	Withdrawal	This node refers to the co- researchers references to withdrawal		19	66
Tree Node	The Effects of Drug Misuse on Children	This node details how supportive family can be in relation to addiction but also how 'family issues' can prevent progress	21	63		
Tree Node	What I have seen & what I am called	This node refers to the experience of death and tragedy associated with addiction	12	33		